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BRACHIAL PLEXUS BLOCK — *100 Consecutive Cases*

EDWARD DAMARJIAN, M.D.

The Author. *Edward Damarjian, M.D., of Providence, R. I. During the War, Chief Anesthetist, 48 Evacuation Hospital, and later on the anesthesia staff at Valley Forge (Pa.) and Chief Anesthetist at Woodrow Wilson (Va.) General Hospitals.*

THIS paper consists of a series of 100 consecutive cases of brachial block regional anesthesia done at this hospital. All cases were done for the Orthopedic Service.[1] The type of surgery varied from a simple excision of a scar or capsulotomy to excision of head of the radius, removal of carpal bones, sequestrectomy of radius, ulna, or lower two-thirds of humerus, amputation of fingers, surgery about the elbow joint, and removal of bone plates from forearm.

No failures were encountered in these 100 consecutive cases. The reason for this success, we believe, is due entirely to the premise that to accomplish a successful brachial block, the anesthetist must necessarily obtain paresthesia, and, secondarily, he should be sufficiently acquainted with his anatomy of peripheral nerve distribution to be able to inject the remaining cords of the brachial plexus by using his original paresthesia site as his guide. Ideally, then, the operator should obtain three paresthesias, one for each of the three cords, to obtain a good brachial block. We definitely disapprove of merely depositing a given volume of an anesthetic over the first rib, as suggested by many authors, and then anxiously hoping that the first stroke of the surgeon's knife will not elicit pain. The correct method, we feel, is to stay with your patient until you have obtained the proper paresthesia and the correct anesthesia for the expected surgery before the patient leaves the anesthesia room. This can be done with the least possible trauma in capable hands, but the promiscuous probing with the needle by the novice, searching for paresthesia, is not considered good technique. If correctly done, with paresthesias obtained, the anesthetic will take effect immediately and there is no waiting period as popularly believed. The anesthesia will last from 1½ to 2½ hours and the dangers of inhalation or intravenous anesthesia are avoided.

The brachial plexus is formed by the anterior divisions of the last four cervical and first thoracic nerves to form three main trunks called upper trunk, middle trunk, and lower trunk. Each of these three trunks divides into anterior and posterior divisions and then the divisions reunite to form the cords which lie beneath and cephalad to the clavicle. The lateral or upper cord which is formed by the anterior divisions of the upper and middle trunks extends peripherally to form the Musculocutaneous nerve, and also sends another branch to join with a branch of the medial cord to form the Median nerve. The other branch from the median cord extends to form the Ulnar nerve. The posterior divisions of all three trunks unite to form the posterior cord which, in turn, without dividing like the other two cords, extends to form the Radial and Axillary nerves.

From this anatomical distribution, one can determine, upon supraclavicular injection, which cord has been injected by noting the peripheral paresthesia produced. Furthermore, once a paresthesia has been effected, one can tell by orientation whether to direct his needle medialy or laterally to inject the other two cords. For instance, if the operator's original injection produced a paresthesia of ulnar distribution indicating medial cord injection, then he knows that he must direct laterally to inject the posterior cord for radial distribution, and again still more laterally to produce paresthesia of the lateral cord. Then again, if he injects and produces paresthesia of radial distribution showing that he has injected the posterior cord, then he must direct the needle both laterally for the lateral cord, and medially for the medial cord. Finally, if

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[1] Appreciation is extended to Lt. Col. Leonard Barnard, M.C., Chief of Orthopedics, for his cooperation in obtaining this series of cases.

he produces paresthesia of the lateral forearm on his original injection, showing that he has injected the lateral cord to produce the paresthesia of the Musculocutaneous nerve, he must then inject medially for the posterior cord and again still more medially for the medial cord.

Since the operator must ascertain from the distribution of paresthesia resulting from his original injection as to which cord he has injected, it is important that he have exact knowledge as to the peripheral distribution of each of the three cords injected. To insure against possible error, we have prepared a large size diagram of the brachial plexus with peripheral distribution in color corresponding to the cord that enervates the area. This allows for quicker decision and less possible chance for error. It is important then to know that the entire medial side of the arm, forearm, and 1½ fingers both dorsally and ventrally are supplied by the medial cord. In the upper arm the area from mid-humerus to the axilla is supplied by the Intercostobrachial, which originates at T-2 and therefore is not anesthetized in a brachial block. Then again, one must know that the Median nerve supplies the lateral area of the forearm (Musculocutaneous) to the wrist, medial half of the volar surface of the forearm, including 3½ fingers of the hand, and also the dorsum of the distal half of the three middle fingers, including the mesial surface of the thumb. Finally, the posterior cord supplies the lateral and posterior area of the upper arm, the midportion of the dorsum of the forearm, and the lateral area of the dorsum of the hand, including 3½ fingers, but including only the proximal half of the three middle fingers.

From this nerve distribution then, it is important that both lateral and medial cords be injected for a Median nerve distribution, the posterior cord for the radial distribution, and median cord for Ulnar nerve distribution. However, unless the operative site is clearly a limited area like an amputation of a finger, or capsulotomy of a phalangeal joint, one finds that at least two paresthesias must be obtained, and we further compensate for the absence of the third paresthesia by depositing a small volume of the anesthetic solution at the transverse process of the cervical vertebra corresponding to the cord that has been missed. For instance, the transverse process of C-5 is injected for the upper cord, C-6 for the posterior cord, and C-7 for the medial cord. This method, we feel, modifies the idea of Labat, who describes the deposition of the anesthetic at Chassaignac's tubercle (6th transverse process) in one of his techniques. The transverse processes are palpated by their relation to the cartilaginous landmarks of the neck. C-5 is opposite the crest of the thyroid cartilage, and C-6 is opposite the cricoid cartilage. In those instances where only one paresthesia can be obtained, two injections of solution are made at the tip of the transverse processes of the corresponding cervical vertebrae.

The technique consists always of a supraclavicular approach. The length of the clavicle is not used as a guide because of its variability. If the Subclavian artery is easily palpable, the site of injection is one fingerbreadth lateral to it and also a fingerbreadth above the clavicle. If the artery is palpated with difficulty then we use the Scalenus Anticus muscle as a landmark. A shortened No. 22 spinal needle, with a very short bevel to prevent piercing the nerve cord, is used directing the thrust towards the first rib. The necessary depth varies from ½" to 1½" and the midlle and index fingers should be used as a guide on the shaft of the needle to prevent deeper penetration. If the rib is not contacted, then the direction of the needle is at fault. In no instances have we observed any unusual reactions, although in some instances, have obtained arterial blood without causing any harm. Only one skin puncture is made and all paresthesias and transverse cervical vertebrae injections are made from this one skin entry.

The long-clavicle type, flat-chested patient is easily blocked. It is the short-neck, barrel-chested patient with acute S-shaped clavicle that gives the most trouble. It has been our experience in these cases to direct the needle superiorly instead of towards the first rib, and attempt to inject the cords as they are formed by the six various divisions of the trunk midway between the cervical vertebrae and the first rib. Invariably, in these patients, the 1st rib forms a very acute angle and the convexity of the rib extends hardly beyond the sterno-clavicular junction. The rib may be missed by the needle if the usual supraclavicular attempt is made by the operator. Furthermore, in this type of patient, paresthesias are frequently easily encountered when injections are made toward the transverse processes of the cervical vertebrae and not toward the first rib.

Only 5 cc of solution (metycaine 1½%) is deposited at each paresthesia site. Thus, a brachial block is completed with a total volume of 15 to 20 cc of solution. We have noted that a larger volume of solution will tend to cause a complete motor paralysis of the arm. This type of complete paralysis is not desired by the orthopedic surgeon, especially when the surgeon needs some voluntary motor control by the conscious patient to help him identify structures. However, in surgery involving considerable trauma, the effects of the larger dose is preferable. When the anesthetic effect of the block begins to disappear, the motor function will return while sensory anesthesia continues to persist for sometime.

We have found that Metycaine 1½% is more

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OUT-PATIENT ELECTRIC CONVULSIVE THERAPY*

LAURENCE A. SENSEMAN, M.D.

The Author. *Laurence A. Senseman, M.D., of Saylesville, R. I. Director, Fuller Memorial Sanitarium, South Attleboro, Mass. Assistant in Neuro-psychiatry, Memorial Hospital, Pawtucket, R. I.*

SHOCK therapy is by no means a new form of treatment. Various forms of it have been used ever since the treatment of mental illnesses was first begun. Some of these earlier forms of therapy can now be reviewed with amusement and others with dismay. It was not until the last two decades, however, that shock therapies in the form of insulin-coma, metrazol and electric-convulsive treatments have constituted a dependable weapon in the psychiatrists armamentarium for the alleviation of the distressing symptoms of the psychotic patient and more specifically the pathologically depressed individual. Ever since Sakel's[1] work in 1928 with Insulin, there has been a growing interest in shock therapy. Meduna[2] introduced metrazol-convulsive therapy in 1934 and in 1938 Cerletti and Bini[3] convulsive therapy by the passage through the brain of an electric current. Due to its convenience, the rapidity with which the patient is induced into a convulsion, and its margin of safety, this form of treatment has become increasingly popular with many psychiatrists and institutions in the treatment of the mentally sick. More recently electric shock therapy has been given to patients on an out-patient basis,[4,5] mostly for the milder forms of illnesses that do not require institutional supervision. In this way many early cases are relieved of their distressing complaints making hospitalization unnecessary.

It is my purpose to review a small series of cases which we have completed on an out-patient basis at the Fuller Memorial Sanitarium in South Attleboro, Massachusetts. The type of equipment used at this institution is the Reiter Electrostimulator[6]. This apparatus is considered to induce a milder convulsion by delivering a smaller current for a little longer period of time than other types of electric shock apparatus. The average dosage is from 60-70 millamps and the average time from 1-3 seconds.

Preliminary to the application of the treatment, about 11:00 a.m., the patient is permitted to eat a light breakfast, to be accompanied by a responsible relative or friend and to sign a permit blank. After bladder and bowels have been evacuated, tight clothing loosened and shoes removed, the patient lies on a rigid truck with a pillow under the lumbar spine for hyperextension. The electrodes are placed over the motor area, usually on the left side, one just above the ear and the other on the vertex. Salt jelly is then placed under the electrodes and a nurse with rubber gloves holds them in place. A second nurse is stationed by the upper extremities and a third by the lower extremities to control excessive motility of these parts during the seizure. A mouth gag is placed between the teeth after all dentures have been removed. The electrical current is then passed through the patient's head and the convulsive seizure induced. There is usually a quick tonic phase of the convulsion during which the body is hyperextended and the arms and legs are rigid followed by a tonic-clonic convulsion lasting approximately 60-100 seconds. The patient then becomes flaccid and respiration is shallow until deep breathing begins relieving a temporary cyanosis. With prolonged apnea artificial respiration is helpful. The patient responds to questioning in about 3-5 minutes after the treatment and on some occasions may be confused, but rarely excited. Occasionally a patient becomes nauseated and vomits or presents incontinence. Most of them have a short period of amnesia which rapidly clears. Following the seizure they remain lying down for the next hour. As a rule the patients are able to leave the Sanitarium after a period of an hour to an hour and a half. We usually advise that they go home by automobile and remain quiet for the rest of the day, though some younger patients have resumed work on the same day. No complications were encountered in this series of cases.

It is of interest to note that with a number of our patients we have given very few treatments, partly because of the mildness of their illness and with others because of their fear of the treatment and failure to return for further administrations. Our best results have been obtained in those who have received three to six treatments and these usually have been depressed patients.

Discussion

There are certain disadvantages of this form of therapy. The most important is the fear associated with the treatment which keeps the patient from

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*Presented at Butler Hospital Staff Conference, February 5, 1946.

returning after some degree of improvement is obtained. Then, too, the patient is not under close supervision following treatment and one must rely on others to interpret the results to a large extent. We believe that the number of beneficial results obtained, however, outweigh these disadvantages.

Of this group of patients treated on an outpatient basis, 6 were males and 24 were females. One hundred twenty-three treatments were given or an average of 4.1 treatments per patient, with a range from 2 to 11 treatments. Ages varied from 16-71 with the largest number (10) between 30 and 40 years of age. Our results may be summarized as follows:—

9 or 30.0% were greatly improved
13 or 43.4% were improved
8 or 26.6% were unimproved

Of the depressed group of 17 patients, 9 or 46%, were considered greatly improved, 6 improved or 40%, and 2 or 13% unimproved.

An illustration of the response of a depressed patient after three electric-convulsive treatments:

Case No. 4, age 54, white, male, adult who gave a history of being depressed in 1919 and spending one year in a mental institution. In 1929 he was again depressed and in 1938 spent three months in a mental hospital. He stated that he was well up until one week previous when he began to lose his appetite, experienced jumpy sensations in his abdomen, and was obsessed with the idea of suicide and felt compelled to do so. He also stated that he had many morbid fears and had lost some weight. He was unable to sleep at night, taking 2-3 Seconals at bedtime.

On physical examination his blood pressure was 150/80; pulse, 88. E.N.T. not remarkable. Chest had some musical rales typical of an asthmatic condition. Heart was normal, not enlarged, regular rhythm. Abdomen was negative for masses and tenderness. There was, however, a small lump in the left epididymis.

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	Name	*Age*	*Sex*	*Diagnosis*	*No. E.C.T.*	*Results*	*Remarks*
1.	R. W.	43	F	Manic Depressive—Depressed	3	greatly improved	Depressed every 6-8 mos.
2.	C. L.	40	F	Manic Depressive—Depressed	5	greatly improved	Improved after 1st E.C.T.
3.	E. S.	32	F	Manic Depressive—Depressed	3	greatly improved	Numerous previous episodes
4.	H. C.	55	M	Manic Depressive—Depressed	3	greatly improved	Four previous episodes lasting 4-6 mos.
5.	A. L.	61	M	Manic Depressive—Depressed	3	greatly improved	Depressed 3 mos. 1944 Hospitalized. Depressed 1 mo. 1945, a bit overactive after 3ECT.
6.	L. T.	28	F	Depressed	3	improved	Responded after 1st treatment
7.	A. W.	51	F	Depressed	3	improved	Previous episodes and this time asked for E.C.T.
8.	H. G.	57	F	Depressed	3	greatly improved	Further treatment not necessary
9.	M. H.	37	M	Depressed	6	greatly improved	Attempted suicide before E.C.T. Has worked 1 yr. but again depressed
10.	L. S.	37	F	Depressed	3	greatly improved	Several previous depression
11.	M. M.	71	F	Depressed	5	improved	Several yrs. of depression
12.	J. M.	39	F	Depressed	2	improved	Responded after 1st E.C.T.
13.	A. S.	61	F	Depressed	11	unimproved	Been depressed 7 years
14.	A. B.	35	F	Depressed	3	unimproved	Failed to keep further apts.
15.	H. W.	34	F	Psychoneurotic Depression	7	improved	Severe agitated depression with marked ambivolence
16.	J. C.	48	F	Psychoneurotic Depression	4	improved	Much more push and interest in home
17.	A. A.	60	F	Involutional Melancholia	4	greatly improved	Estrogenic substance given until discharged as well
18.	W. P.	47	M	Psychoneurosis	5	unimproved	Severe with cardiac neurosis
19.	M. M.	38	F	Psychoneurosis	6	unimproved	Institutionalized later
20.	R. B.	42	M	Psychoneurosis	5	improved	Depression element was relieved, later given more E.C.T. at another hospital and is now well
21.	V. P.	29	F	Psychoneurosis	3	improved	Obsessive compulsive neurosis
22.	A. C.	57	F	Psychoneurosis	4	improved	Coughing every 5 seconds, complete relief of cough
23.	P. M.	39	M	Schizophrenia	2	unimproved	Failed to return
24.	O. D.	16	F	Schizophrenia	7	unimproved	Sent to State Hospital (better after Sod. amytal)
25.	E. B.	44	F	Schizophrenia (Paranoid)	5	unimproved	Sick 10 yrs. and been in State Hospital. Family felt there was improvement
26.	B. G.	20	F	Schizophrenia (2nd episode)	3	unimproved	Transferred to another hospital
27.	G. W.	34	F	Schizophrenia	4	improved	Now working
28.	R. J.	25	F	Schizophrenia	5	improved	Was able to return to home in Minnesota
29.	B. M.	22	F	Schizophrenia (2nd episode)	3	improved	Able to return to work
30.	T. K.	31	F	Schizophrenia	4	improved	Delusions were much better controlled

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This patient was given his first convulsion on 3/21/45 and again on the 25th and again on April 12. At this time he stated that he felt very well and wanted to return to work. He also indicated that he felt he was coming out of the depression as he knew what the sensation was, having experienced this on three separate occasions before. He also stated, "you can give me another electric shock treatment but I feel that I am now well." He was able to return to work at this time, and to date has carried on his usual work as treasurer of a large manufacturing concern.

An illustration of the psychoneurotic response to three electric-convulsive treatments:

Case No. 21, age 29, wife of an Ensign in the Navy who had a marked obsessive compulsive neurosis and who spent most of her time preparing for bed, but feeling that such preparations were never quite complete. She was very ritualistic in her behavior, spending a great deal of time with her hair, fingernails and make-up. She was nervous, apprehensive and tense, though pleasant, cooperative and rational at all times. No psychotherapy was attempted as she was referred by another doctor for electric-shock treatment. This was given at the Sanitarium on four separate occasions. Her husband stated that he felt that she was improved, as she spent less time taking care of her person, and became more interested in her surroundings, especially in her home. After three treatments she was able to get out and mix with others socially. This was quite a departure from her previous routine of limited activities and while she is not completely well considerable improvement is apparent.

Conclusions

1. Electric shock therapy can safely be given on an out-patient basis.
2. Depressed patients showed the most favorable response in this series of cases.

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[5] Wender, Louis, Balser, Benjamin H. and Beres, David: Extramural Shock Therapy, Am. J. Psychiat., 99:712 (March) 1943.

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desirable than Procaine 2%. The length of time that anesthesia persists with Procaine is quite unpredictable, varying from 50 minutes to 1½ hours; whereas, Metycaine lasts from 1½ to 2½ hours.

For example, let us suppose our candidate for brachial block is a robust patient of short stature, short neck, and S-shaped clavicle. We first attempt the ordinary supraclavicular approach directing the needle towards the first rib. If the rib is easily contacted, we continue to locate our three cords. If the rib lies medially at the sterno-clavicular junction, we direct the needle towards the cervical vertebrae and attempt to cause paresthesia of the cords at a higher level closer to their origin from the divisions of the nerve trunks. From our diagram we know that injection of the medial cord not only blocks the Ulnar nerve, but also part of the nerve fibers that go to make up the Median nerve. Now if paresthesia of the lateral cord is missed, we know that part of that cord is blocked because of the contribution it receives from the already blocked medial cord. Then, to insure a good block, 5 cc of the solution is deposited at the tip of the transverse process of C-5. If our original paresthesia involved the lateral cord and we had missed the paresthesia of the median cord, then we again realize that we have blocked the Musculocutaneous nerve and only part of the Median nerve, because this nerve also receives a contribution from the medial cord. In this instance, we deposit 5 cc of the solution at the tip of the transverse process of C-7. Chassaignac's (C-6) tubercle is used for a missed posterior cord block. A good index of posterior cord block is the isolated area of supply of a small patch of skin over the dorsum of the first interosseus space, ennervated by the Musculospiral nerve. All injections are made from the original supraclavicular skin puncture.

Complications

As we have mentioned previously, we have encountered no frank failures, but have had to supplement the block toward the latter stages of the operation. This has only occurred in 7 cases, and these have all occurred with 2% Procaine. In another 8 cases, intravenous morphine was given for apprehensive patients who originally desired to be put to sleep. In those cases that were supplemented, we used Pentothal 2½%. In our previous paper[2] we noted that only .44 cc/min of intravenous Pentothal was necessary for patients who previously had a regional block.

We had no serious complications. In three instances, patients complained of vague paresthesia sensations for 3 days. Two patients complained of

[2] Pentothal Anesthesia—Journal of Anesthesiology. August, 1945.

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RHODE ISLAND BLOOD-PLASMA PROGRAM

(The American Red Cross is furnishing dried blood plasma without charge for use in civilian medical practice. This material was prepared from blood collected by the American Red Cross for the Army and the Navy and has now been declared surplus to their needs. Supplies of this surplus plasma are provided to State Departments of Health by the American Red Cross for distribution to all physicians licensed to practice medicine and surgery and to all acceptable hospitals for use without charge for the product.

The standard army-navy package consists of a sealed outer carton containing two metal cans. One holds the bottle of dried plasma, the other the distilled water for reconstitution of the plasma. The necessary tubing, needles, and other equipment required for reconstitution and administration of the plasma are also contained in the two metal cans. Instructions for reconstitution and administration are lithographed on the outside of the metal cans. Most of the packages also contain a report form to be filled out and mailed to the Army or Navy Medical Center. This report form is not to be used for local or state studies and is not to be mailed to the Army or Navy. Instead you are to use the form supplied by the State Department of Health.)

In accepting the responsibility to act as Sponsoring Agent for this area, the Rhode Island Department of Health has devised a program that resolves itself into two phases; (1) distribution of plasma and (2) establishment of a blood-plasma bank.

1. *Distribution*

At the commencement of this program, each hospital and maternity home licensed by the State and those operated under its auspices will be allotted one plasma unit for each four beds utilized for acutely ill patients. Each physician licensed by this department to practice medicine and surgery will be allotted one plasma unit.

The hospital allotments will be delivered to them by the ordinary avenues at the disposal of this department, aided by the motor corps of the local chapter of the American Red Cross.

The physicians may obtain their unit by applying at the various hospitals where they have staff appointments, or they may obtain it directly by calling at the Division of Narcotic Drugs and Pharmacies, State Office Building, or at the various district health units of the Department of Health located in Woonsocket, West Warwick and Bristol.

To obtain an original issue or a replacement of a unit, each hospital and physician must fill in the form supplied by the Department of Health. The purpose of this form is to keep an accurate inventory of supplies on hand and too, the expiration date of that plasma which is at large at the hands of the hospitals and physicians.

No charge whatever is to be made to any patient for the plasma supplied under this program. It is understood, however, that the institutions and/or physicians may justly charge for the professional services entailed in the administration of the plasma.

2. *Blood Bank*

At present the Department of Health has no facilities for the storage of whole blood, the processing of blood to recover dry plasma or the fractionation of either blood or plasma. Massachusetts has such facilities, and it is not amiss to hope that at a future date Rhode Island will be so equipped. In the interim it is suggested to the various institutions and physicians that for each unit of plasma used, the patient be solicited to procure or provide a blood donor. This donor will give an equal amount of whole blood to the physician or institution participating in the blood-plasma program.

Whole citrated blood may be preserved under aseptic conditions for seven to ten days with refrigeration. At the end of this period it may still be processed into dry plasma or fractionated. Blood-plasma which has reached its expiration date may also be fractionated. At the present time we have information that any of these above-mentioned processes can be done by the larger pharmaceutical houses at a cost in the neighborhood of $15.00 per 250 cc. unit. It will be quite understandable that this would prove an expensive procedure considering the fact that blood-plasma is now available free of charge to any patient regardless of their ability to pay. However, by following the above-mentioned suggestions, all institutions in our State should be able to have on hand at all times a quantity of fresh whole citrated blood and blood-plasma. Even if the blood must be discarded at the end of ten days the institution will have the added insurance of having had it available for emergency use.

INDICATIONS FOR TRANSFUSION*

Indication	WHOLE BLOOD		PLASMA OR SERUM	
	Choice	State (fresh or preserved)	Choice	State (fresh liquid, stored liquid, frozen, dried)
Shock due to hemorrhage (traumatic shock)	First[1]	No preference	Second	No preference
Shock with hemoconcentration — Initial treatment (burns, crush syndrome, and abdominal injuries)	Second	No preference	First	No preference
Hypoproteinemia	Second	No preference	First	No preference
Acute and chronic anemias	Imperative	No preference	Not indicated	
CO poisoning and methemoglobinemia	Imperative	No preference	Not indicated	
Immune therapy	Second	No preference	First	Fresh liquid, frozen, or dried
Deficiency of complement	Either	Fresh	Either	Fresh liquid, frozen, or dried
Deficiency of prothrombin	Either	Fresh	Either	Fresh liquid, frozen, or dried
Leukopenia and thrombocytopenia	Imperative	Fresh	Not indicated	
Hemophilia	First	Fresh	Second	Fresh liquid, frozen, or dried

[1] The recommendation of first and second choice is made on the assumption that both blood and plasma are immediately available.

* Table adapted from OCD Technical Mannual, "The Operation of a Hospital Transfusion Service."

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paresthesia of ulnar distribution without sensory or motor loss, and the paresthesia of both of these patients lasted for three weeks. Since orthopedic surgery was done under pressure tourniquet, it is questionable as to whether the block or the pressure tourniquet contributed to these paresthesias.

One other patient complained of chest pain after returning to his ward. X-ray showed a small pocket of air beneath the dome of the right pleura. Patient's symptoms disappeared in two days. No other complications were noted among the rest of the patients that were blocked and no instances of "reaction" to the anesthetic drug occurred.

Summary

We have presented a series of 100 consecutive brachial blocks. For repeated successful blocks, it is necessary that an operator have a good knowledge of the anatomy of the brachial plexus and its exact peripheral distribution. Furthermore, paresthesias must be elicited to insure proper block anesthesia in every case. We feel that this type of anesthesia eliminates many of the hazards that would be encountered in inhalation or intravenous anesthesia. Brachial blocks have become popular among the patients of this hospital and many requests are made for this type of anesthesia in preference to the popular Pentothal.

R. I. HOSPITAL REFRESHER COURSES FOR VETERAN-PHYSICIANS

STANLEY S. FREEDMAN, M.D.

The Author. *Stanley S. Freedman, M.D., of Providence. Assistant Physician, Department of Pediatrics, Rhode Island Hospital.*

SPONSORED by the Post-Graduate Medical Education Department of Tufts Medical School, and in conjunction with several other hospitals, the R. I. Hospital has opened its clinical and teaching facilities in Pediatrics, Pediatric Surgery, and Allergy to a small, enthusastic group of recently discharged Medical Corps Officers. The men were New England physicians whose military duties prevented them from keeping up with advances in non-military medical subjects. The course included many topics and extended over a period of 12 weeks. It originated in Boston and ended in Providence. It included Medicine which was given at the Joseph H. Pratt Diagnostic Hospital; Surgery at the Boston City Hospital; and Obstetrics at the Lying-In Hospital of Providence. When this group completes its studies, a second "wave" of physicians is expected to arrive, and the process will be repeated.

The Pediatric Department and its staff, headed by Dr. William Buffum, and assisted by members of other departments conducted the course. Lectures, discussions, demonstrations, and ward rounds were held. The lectures were informal and were conducted in an atmosphere of mutual exchange of knowledge and information, the students often expressing their ideas and relating previous experiences.

Dr. Harold Calder gave a scholarly review on the subjects of tetany, diseases of metabolism and infant feeding. Dr. Henry Utter gave an inspiring talk on Diseases of the New Born. Dr. Robert Lord spoke on Special Problems encountered in pediatric practice. Dr. Reuben Bates dwelt on the problems of pylorospasm and pyloric stenosis. The Coeliac Syndrome, its classification, differential diagnosis, and management were covered by Dr. Herman B. Marks. Dr. Maurice Adelman returned from Florida just in time to give a two hour lecture on haematology, and Dr. John Langdon tackled nephritis and nephrosis. Respiratory Diseases and their present day management, were discussed by Dr. Arthur R. Newsam. Dr. Kalei Gregory's talk on preventive pediatrics was practical and up to date, including the latest reliable information on this vital subject.

Epidemic diarrhea of the new born and its tragic consequences is only too well known to all of us. It was Dr. William S. Bell who made a thorough and impressive presentation of this important subject. Dr. Edward West conducted ward rounds and demonstrations at the Charles V. Chapin Hospital. A motion picture depicting isolation-technique and treatment of contagious diseases was very instructive. A complete review of congenital and rheumatic heart disease was rendered by Dr. Walter T. Zimdahl.

The Surgical, Orthopedic, and Eye Departments contributed generously to the course. Dr. Wilfred Pickles lectured on Pediatric Neuro Surgery, paying particular attention to such problems as subdural hemorrhage in the neo-natal period, spina-bifida and hydrocephalus. Dr. Kenneth G. Burton discussed the diagnosis and treatment of congenital orthopedic anomalies, with emphasis on hip dislocation and hip infection. The surgical treatment of pyloric stenosis and intussusception was described by Dr. Frank B. Littlefield.

Dr. Frederick Stevens took up the subject of cataract and strabismus, and Dr. Lee Sannella described lacrimal sac infection in infancy.

A most interesting program on Neuropsychiatric Disorders in Childhood was presented at the Emma Pendleton Bradley Home in which Dr. Charles Bradley and his staff participated.

In the realm of Allergy Drs. William Buffum and Stanley Freedman delivered several lectures and demonstrations. Dr. Buffum with his usual enthusiasm opened with a general statement on the nature of allergy. Then followed a detailed talk on bronchial asthma and a presentation of several difficult cases. Dr. Freedman took up pollinosis and perennial vaso motor rhinitis. The latter was discussed in relation to pulmonary allergy in general. A demonstration in the technique of cutaneous testing was given in the Out-Patient Department.

Five medicos took the first course. They were Dr. Joseph Colman from Mansfield, Mass.; Dr. Sam Klouber from Boston; Dr. John F. Dougherty from Bath, Maine; Dr. Charles Moors from Rochester, N. H.; and Dr. Stanley R. Lenfest from Waldoboro, Maine. All were overseas veterans of World War II. One wore the Purple Heart. All expressed gratitude for the "kindly reception and excellent instructions" they received at the Rhode Island Hospital.

RINGWORM OF THE SCALP

(Due to interest and enthusiasm of Dr. William B. Cohen and Dr. Carl S. Sawyer, both members of The Dermatology Department at the Rhode Island Hospital, we have learned of the importance of the following subject and are able to give you this interesting resume.)

THE hair is woman's crowning glory and the appearance of a grey hair or the loosening of a hair shaft in its follicle is a calamity. The balding man is ever conscious of his receding hairline and is often envious of his more fortunate brethren who have a heavy mane at the age of sixty. However, parents are not always as watchful of their children's scalps as they are of their own. Or more likely, they are not cognizant of disease. Consequently it is the responsibility of the doctor to recognize disease of the scalp and preserve that important function of growing hair until time, worry, and the genes make his efforts fruitless.

The Dermatology department at the Rhode Island Hospital would like to bring to the attention of the medical profession at large the recent increase in the number of cases of Tinea Capitis or ringworm of the scalp in children seen in the Out-Patient department. During the past five months the number of new cases seen is more than can be considered sporadic. Most of these patients are Negro or Portuguese children who come from a small section of Providence near Fox Point, but there have also been cases from other sections of the City. The number of cases has not reached and is not likely to reach the epidemic proportions reported in other larger cities, but the definite increase in numbers is a warning to all physicians to be watchful for this condition.

Tinea Capitis is a disease primarily of children though it does occur occasionally in adults. It is important to recognize and treat the infection early because of its contagiousness and because untreated the disease may go on to permanent baldness.

The disease may be caused by several fungi, the most common of which in this section of the country is Microsporum Laposum, the so-caled "animal type" or the species which is also pathogenic for animals. The species Microsporum Audouini (human type and not as pathogenic for animals) is much less common in the Eastern states. Other organisms such as Achorion Schonleinii, which causes favus, and the Trichophytons are still less common but must be considered. Bald, crusted, scaly and pustular areas may very likely be ringworm.

The leions caused by M. Lanosum and the Trichophytons in general tend to be inflammatory with pustulation and boggy induration. The lesions start as papules surrounding a hair, spread peripherally and coalesce to form large patches in which may be seen broken off hairs.

The lesions caused by M. Audouini and by Achorion tend to be less inflammatory with less oedema and more scaling. This type is of greater infectivity, spreading from child to child and is usually the organism involved in epidemics of ringworm of the scalp. The more inflammatory types caused by M. Lanosum are less contagious, less likely to lead to permanent baldness, and occasionally heal spontaneously. This type of Tinea heals readily with local application of fungicides and daily washing.

M. Audouini causes an infection which is particularly resistant to treatment and nearly always requires X-ray epilation. Untreated, these cases may have permanent bald patches.

It is fortunate that nearly all the cases seen in this clinic have been caused by M. Lanosum and have been amenable to local treatment. There is little chance of the disease assuming epidemic proportions, but this fact does not lessen our responsibility in recognizing the disease early and instituting proper treatment.

It is recommended that:

1. a careful inspection of the scalp be included in the routine examination of school children.
2. a recognized case be excluded from school.
3. a suspected case be subjected to microscopic and cultural studies by sending a good number of the broken-off infected hairs, which are easily pulled out, to a laboratory to confirm the diagnosis and determine the causative organism.
4. the hair be clipped very closely.
5. the patient wear a stocking cap at all times. It may be changed and washed daily.
6. the parents be instructed in daily manual epilation in the infected areas followed by application of a suitable fungicidal preparation.
7. cases resistant to treatment or caused by the human type of organism be given X-ray epilation before permanent alopecia occurs.

Pediculosis Capitis and impetigo of the scalp are more common diseases and are easily recognized, but it takes only a little more care in examination to notice that in Tinea there are no nits and that the hairs are broken off.

The RHODE ISLAND MEDICAL JOURNAL

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SICKNESS ACT AMENDMENTS

(At the time the following editorial was written the legislation to which it has reference (see page 286) had been passed by the House of Representatives and referred to the Senate Committee on Labor. As the Journal goes to press we are informed that the Senate reported the amendments out with approval.

The Editors)

In May, 1943, when the state cash sickness compensation act was amended to alter its original purpose, Dr. Emery M. Porter, then President of the Providence Medical Association, cited in MEDICAL NEWS, official publication of the Association, the wide implications of the amendments, and the dangers involved. Dr. Porter received little support from the Board administering the program, or from the public at large; on the contrary, he was criticized for his views. Last month, however, the special commission appointed by Governor Pastore substantiated what Dr. Porter had so clearly forseen three years ago.

The legislation introduced as the result of the Commission's report remedies some of the problems, and postpones to a future date others. Of particular significance however, is the provision in the new amendments for the creation of a cash sickness advisory committee of seven members representing labor, the general public, the medical profession, and the general assembly. This new committee is to review the activities of the administration of the sickness fund monthly, file quarterly reports with the Board, and an annual report to the Governor containing recommendations as to the administration, management and operation of the fund. Here then, is belated recognition of the fact that the program is a community enterprise and not merely a state project subject to the administrative desires of a politically-appointed board.

Of particular interest to the medical profession is the amending of the definition of sickness long advocated by the State Medical Society. The new wording provides that an individual shall be deemed sick when he is unable to perform his *regular or customary work.* Now physicians are obligated to testify on the report form that the patient *is unable to perform any services for* wages, a most restrictive provision in view of the purpose of a temporary disability program.

The House of Delegates of the Rhode Island Medical Society, in February, 1945, recommended that complications of pregnancy be compensable under the sickness program, but that pregnancy should not. It also recommended that if maternity benefits were to be allowed the beneficiary should receive them for the six weeks prior to and for the

six weeks immediately after the due date of delivery of a child. The Commission recommended, and the legislation introduced provided for, a total of fifteen weeks of benefits due to sickness resulting from pregnancy, whether such sickness be prenatal, postnatal, or a combination of both; provided, however, that these limitations shall not apply to unusual complications arising as a result of childbirth. Just what is to determine an "unsual complication" is apparently left to the discretion of the Board administering the act.

Taking cognizance of the fact that an appeal of a claimant upon the discontinuance of his benefits by the Board under the existing law goes back to the same board, the Commission recommended and the new amendments provide for, a special board of review of three members, one of whom shall be a representative of the medical profession, one the public, and one of employees. However, the only appeals that would reach this review board would be those on which the unemployment compensation board had not reached a *unanimous* decision. The problem here is twofold. On the one hand the unemployment compensation board can be unanimous in the majority of its decisions, thus resulting in very few appeals reaching the new board of review, and thereby subverting the purpose of the amendment. On the other hand, if every claimant aggrieved by any decision of the UCB takes his case to the board of review, the latter board will necessarily find itself on full-time duty.

The compromise would appear to be the position advanced by the representatives of the State Medical Society at the hearings before the Commission. One or more impartial medical representatives might sit with the UCB at appeal hearings and assist in the reaching of a fair decision, since most appeals are based on claim of physical inability to resume work.

On one other point must we take exception. That is the proposed amendment that to safeguard the fund an educational program *must* be undertaken by the UCB to publicize the need for accident prevention and the preservation of health, the need for industrial employment to provide the best available safeguards for workers, and the need for appropriate sanitary facilities. This is not the task of the unemployment compensation board. It is the work of the state and municipal health departments, and the statutes already provide for the mechanism to carry out all of these phases of health education. While it may be commendable that the UCB cooperate in the work of health education, within the scope of its own sickness act program, yet it would appear far more advisable that the framework of the state health department be strengthened to achieve this purpose. The new health code allows the state director of health to establish a division of health education, and it also clarifies and improves the provisions relative to the control of industrial health in this state.

If the cash sickness compensation program is to expend its funds for public health and for industrial health education work, then it is reasonable to give consideration to the proposal that some thoughtful study be given to the coordination of the cash sickness compensation program and the curative center of the state labor department under a separate Public and Industrial Health Commission under the direction of the Governor.

ELECTROENCEPHALOGRAPHY

Rhode Island physicians who have followed the development of electro-encephalography as a new and valuable diagnostic technique in neuro-psychiatry will be interested in learning that on March 1st at a meeting held in Hartford the Eastern Association of Electroencephalographers was organized. This is the first official association of scientists engaged in this work to be organized in this country and should be of assistance in the pooling of research results and the development of standards of application, diagnosis, and terminology in this new field. Approximately thirty-five scientists from the Atlantic seaboard region were present at this organization meeting and elected Dr. Robert S. Schwab of Boston as Chairman and Dr. Charles A. Stephenson of Hartford as Secretary, with future plans for meeting approximately every two months.

Rhode Island was represented at this meeting by Donald B. Lindsley, Ph.D., Director of Psychological Laboratory and Electroencephalographic Research at the Bradley Home. Dr. Lindsley and his predecessor in this position, Dr. Herbert H. Jasper, have during the past eleven years carried out much fundamental research in this field, particularly as it applies to children's neuropsychiatric problems. It is encouraging that other hospitals in the State are developing facilities for electroencephalography after a period of several years during which such examinations were available to Rhode Island physicians only at the Bradley Home.

Program . . . 135th Annual Meeting

RHODE ISLAND MEDICAL SOCIETY

May 15 - 16, 1946 ***At the Rhode Island Medical Society Library, Providence***

WEDNESDAY, MAY 15

2:00 P.M. CALL TO ORDER
WELCOME BY PRESIDENT, John F. Kenney, M.D.
RECOGNITION OF DELEGATES FROM OTHER SOCIETIES

George Blumer, M.D.

2:15 P.M. "THE VIRUS TYPE OF INFECTIOUS HEPATITIS"
GEORGE BLUMER, M.D., of Pasadena, California
(David P. Smith Clinical Professor of Medicine, Emeritus, Yale University School of Medicine)

2:45 P.M. "MANAGEMENT OF CONVULSIONS IN CHILDREN"
CHARLES BRADLEY, M.D., of East Providence, R. I.
(Superintendent, Emma Pendleton Bradley Home, East Providence)

3:15 P.M. "SOME FACTORS ON HUMAN REPRODUCTION"
JOHN ROCK, M.D., of Brookline, Mass.
(Visiting Surgeon and Director of the Fertility and Endocrine Clinics at the Free Hospital for Women, Brookline, Massachusetts; Research Assistant in Gynecology and Obstetrics, Harvard Medical School.)

3:45 P. M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

Thomas E. Jones, M.D.

4:10 P.M. "SURGICAL MANAGEMENT OF CARCINOMA OF THE COLON AND RECTUM"

THOMAS E. JONES, M.D., of Cleveland, Ohio
(Surgeon, Cleveland Clinic Foundation Hospital)

ALLIED MEETINGS

WEDNESDAY, MAY 15

At the R. I. Medical Society Library

THE RHODE ISLAND ASSOCIATION OF MEDICAL RECORD LIBRARIANS

Presiding: Miss Elizabeth Bingham, R.R.L., *President*

10:30 A.M. BUSINESS MEETING

11:30 A.M. "EVOLUTION OF MEDICAL RECORDS"—Henry B. Moor, M.D.
Chief of the Surgical Division, The Memorial Hospital, Pawtucket

12:00 M. "THE MEDICAL AUDIT"—Henry S. Joyce, M.D.
Assistant Superintendent, The Rhode Island Hospital

THE RHODE ISLAND MEDICAL SOCIAL WORKERS

Presiding: Miss Hope L. Joslin, *Chairman*

1:00 P.M. "THE EXPANDED FEDERAL-STATE VOCATIONAL REHABILITATION PROGRAM"

Charles L. Newberry, M.D. of Washington, D. C.

(Surgeon(R) U. S. Public Health Service; Assistant Medical Officer, Office of Vocational Rehabilitation, Washington, D. C.)

Exhibitors at the

135th ANNUAL MEETING OF THE RHODE ISLAND MEDICAL SOCIETY

Space	
1	Winthrop Chemical Company
2	Buffiington's, Inc.
3	Blanding & Blanding
4	Spencer, Inc.
5 & 6	Burroughs Wellcome Company
7	Nutrition Research Laboratories
8	Sharp & Dohme, Inc.
9	Mead Johnson & Company
10	Coca-Cola Bottling Company of R. I.
11	The Claflin Company
12	Doho Chemical Manufacturing Co., Inc.
13	Boss & Seiffert Company
14	White Laboratories
15	The Borden Company

Space	
16	Eli Lilly & Company, Inc.
17	Philip Morris & Company
18	Davies, Rose & Company, Ltd.
19	Smith, Kline & French Laboratories
20	Owens-Corning Fiberglas Corporation
21	Alkalol Company
22	Lederle Laboratories
23	L. & B. Reiner Company
24	Bilhuber-Knoll Corporation
25	U. S. Vitamin Corporation
26	C. B. Fleet Company, Inc.
27	Schering Corporation
28	C. V. Mosby Company
29	Smith-Holden, Inc.

MAKE YOUR RESERVATION *BEFORE* MAY 6 FOR THE DINNER-MEETING AT THE NARRAGANSETT HOTEL ON MAY 15 AT WHICH THE CHAPIN ORATION WILL BE GIVEN. RESERVATIONS SHOULD BE MADE THROUGH THE SOCIETY'S EXECUTIVE OFFICE.

CHANGES PROPOSED IN CASH SICKNESS COMPENSATION LAW OF PARTICULAR INTEREST TO PHYSICIANS

(As passed by the House of Representatives of the Rhode Island General Assembly on March 29, and referred to the Committee on Labor of the Senate)

"Sec. 2.

"(13) *'Sickness.'* An individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform his regular or customary work; PROVIDED, however, that an individual shall be deemed to be sick in any week when such sickness prevents him from being able to perform his regular services, even though such employee is paid his regular wages or parts thereof by his employer for such absence due to sickness."

"Sec. 5.

"(4) *Duration of Benefits.*

"No individual shall be deemed eligible for benefits for a period of excess of 15 weeks for unemployment due to sickness resulting from pregnancy, whether such sickness be prenatal, postnatal, or a combination of both; PROVIDED, HOWEVER, that the aforesaid limitations shall not apply to unusual complications arising as a result of childbirth."

"Section 5

"(b) *Appeal to Board of Review.* The governor shall appoint three persons, not more than two of whom shall be of the same political party to act as a board of appeals, one of whom shall be a representative of employees, one shall be a representative of the public, and one shall be a representative of the medical profession. Members of said board shall serve at the pleasure of the governor and shall be compensated for their service as members of said board at the rate of $25.00 for each day on which said board shall hear appeals in accordance with the provisions of this act.

"Any benefit claimant aggrieved by any decision of the unemployment compensation board, other than a unanimous decision, may within ten days appeal to the board of review. Said board of review may, after such reasonable notice to the parties as it may by regulation prescribe, and after an opportunity for a hearing, set aside or confirm any decision of the unemployment compensation board. The board of review shall promptly notify the interested parties of its findings and decisions.

"(c) *Exhausting of administrative remedies.* A request by any interested party for further appeal, from a unanimous decision of the unemployment compensation board, as provided in this section, in the manner prescribed by the rules of said board, shall be deemed to exhaust the administrative remedies referred to in section 9 (8) of this act; and a refusal by the board to permit further appeal and written notice thereof, shall be deemed a final decision of the board from which appeals may be taken to the courts. A final decision of the board of review shall also be deemed to exhaust the administrative remedies referred to in section 9 (8) of this act, and shall be deemed a final decision from which appeals may be taken to the courts.

"***."

"Sec. 17. The board shall undertake an educational publicity program designed to safeguard the fund created by this act. The board shall solicit the cooperation and assistance of labor, industry, and the public generally, in effecting such program. In the exercise of its authority hereunder, the board shall give publicity to the need for accident prevention, and the preservation of health; it shall publicize the need for industrial employment to provide the best available safeguards for workers, as well as appropriate sanitary facilities. It shall also publicize the potential results of malingering.

"Sec. 18. A committee to be known as the cash sickness advisory committee is hereby created to consist of seven members, five of whom are to be selected by the governor and to serve at his pleasure; of said five members, three shall be representatives of labor and two shall be representatives of the general public; of the two representatives of the public, one shall be a member of the medical profession. The chairman of the labor committee of the senate and the chairman of the labor committee of the house of representatives shall also be members of said committee.

"Said committee shall meet monthly and shall review the activities of the administration of the cash sickness benefit fund. Said committee shall file a quarterly report with the unemployment compensation board and shall report annually to the governor, which said report shall contain recommendations as to the administration, management and operation of the fund. The said committee shall also submit annually to the governor its recommendations as to any proposed amendments to the cash sickness act."

HOSPITAL ASSOCIATION OF RHODE ISLAND

NEW ENGLAND HOSPITAL ASSEMBLY HOLDS ANNUAL CONVENTION

THE New England Hospital Assembly conducted its first Post-War meeting on March 11, 12 and 13 at the Hotel Statler in Boston. The President of the Assembly this year was Mr. Carl A. Lindblad, Director of the Homeopathic Hospital in Providence.

The Assembly covers five hundred and seventy hospitals in the six New England States and as this was the first Post-War meeting, the attendance was the largest in the history of the Association. The registration exceeded twenty-five hundred.

Practically all Rhode Island hospitals were well represented not only by Directors and heads of Departments, but also by various personnel in the detailed operation of Hospitals.

An innovation this year consisted of fourteen sectional meetings devoted to departmental matters and affording excellent opportunity for guidance and information relative to specific departments.

The opening General Session on Monday morning covered Employee Relations. Under this heading present day wages and hours and working conditions were discussed under the leadership of Miss Dorothy A. Hehmann, Director of Personnel at the Grace-New Haven Hospital, New Haven, Connecticut. The subject of Pensions and Retirements was under the direction of Mr. Homer Wickenden, Secretary of the National Health and Retirement Association of New York City. This Association has recently organized a Pension Program for non-profit organizations for the purpose of affording a retirement income for hospital and welfare employees. This meeting brought forth considerable interest and questions pertaining to the subjects discussed. The importance of employee relations is one of very definite local interest to our Rhode Island hospitals and the papers read, as well as the discussion following, will make it possible for our Rhode Island Hospitals to intelligently reach conclusions in dealing with the employee problem.

The noon period was utilized in luncheon meetings by all of the State Associations, some of which conducted short business meetings during the luncheon period.

The Monday afternoon program covered such subjects as Admitting Procedures, Laundry Management, Personnel, Trustee Relations, Accounting, Purchasing, and Service Shops. The Sectional meeting on Admitting Procedures was under the direction of Helen M. Blaisdell, R.N., Superintendent of Westerly Hospital, and the Accounting meeting was under the direction of Mr. Leroy P. Cox, Superintendent of the Woonsocket Hospital.

Public Meeting

On Monday evening, a public meeting was held, which was addressed by Major General Paul R. Hawley, Acting Surgeon General, Veterans Administration, who was introduced by Brigadier General Elliott C. Cutler, M.D., Chief of Staff, Peter Bent Brigham Hospital in Boston, Mass. General Hawley outlined the proposed program of the Veterans Administration and the desire of the administration to secure the cooperation of all local hospitals in the care of returning veterans for service connected disabilities. Under the existing laws, the returning veterans may be cared for in civilian hospitals if convenient for service connected disabilities only and occasionally for emergency conditions that may arise where there would not be sufficient time for the patient to be transferred to a Veterans Hospital. In the case of the female veterans, the local hospitals may, under the law, care for both service and non-service connected disabilities.

It is the desire of the Veterans' Administration, that arrangements be made with all local hospitals for the care of these veterans as the needs arise, and that contracts will be entered into with such hospitals in the very near future.

General Hawley also emphasized that any Veterans Hospitals to be erected would be located in

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N. E. HOSPITAL ASSEMBLY

concluded from previous page

urban areas in order that the Veterans Administration might draw from competent local specialists in caring for the veterans, and assuring them of the best possible professional service.

Group Practice in Hospitals

The Tuesday morning general session was utilized in discussing the very important subject of Group Practice and Changing Professional Relationships as applied to hospital care. Dr. Frederick T. Hill, Medical Director of Thayer Hospital, Waterville, Maine, outlined the procedures in his institution and he was followed by Mr. Donald S. Smith, Superintendent of Mary Hitchcock Memorial Hospital, connected with Dartmouth College in Hanover, New Hampshire. The meeting was also addressed by Dr. Jean A. Curran, Dean of the Long Island College of Medicine, Brooklyn, New York. There is a very definite trend toward Group Practice, especially within the hospitals, in order to assure the patient of the best possible professional advice and service. The speakers, who have had considerable experience with this type of Group Practice, were enthusiastic in their recommendations and no doubt, serious consideration will be given this method of care by the general hospitals.

Meeting on Nursing Procedures

The meeting covering Nursing was in charge of Mr. Oliver G. Pratt, Executive Director of the Rhode Island Hospital and afforded an opportunity for a thorough discussion of nursing problems. Again, on Tuesday afternoon, a series of Sectional Meetings included Dietitians, Medical Record Problems, Credits and Collections, Volunteer Service, Public Relations, Nurse Anaesthetists and Medical Social Service.

Dinner Meeting

The meeting on Tuesday evening was highlighted by the address of Dr. Karl T. Compton, President of Massachusetts Institute of Technology, and although very technical in character, Dr. Compton predicts that the use of scientific knowledge will more and more indicate its value to the medical and allied professions. Dr. Compton indicated that the scientists at the Massachusetts Institute of Technology were working very closely with Harvard and Tufts Medical Schools in perfecting treatment with X-ray, Radium as well as allied energies and he indicated revolutionary methods of care and treatment in the years ahead.

The general session of Wednesday morning brought out the value of Psychiatry in the General Hospital which was presented by Dr. James M. Cunningham, Director, Bureau of Mental Hygiene, State Department of Health, Hartford, Connecticut. A second speaker for this session was Dr. Fred G. Carter, Superintendent of St. Luke's Hos-

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BY-LAW CHANGES ADOPTED BY THE HOSPITAL SERVICE CORPORATION

(Adopted at Board Meeting, February 20, 1946)

ARTICLE III

Board of Directors

"Section 1. *Number and Qualifications.* The affairs, property and business of the corporation shall be managed by a Board of not less than twenty-one Directors, as fixed from time to time by the members. Directors need not be members of the corporation but must be of full age. There shall be one Director nominated by each contracting hospital from its board of directors or trustees. At least one Director out of every four must be a person authorized to practice medicine in the State of Rhode Island nominated by the Rhode Island Medical Society, and at least two directors must be laymen. The Director of Public Health for the time being of the State of Rhode Island or such other official as may from time to time perform the duties performed by such Director at the time these by-laws are adopted shall be a director or ex-officio.

Section 2. *Election and Term of Office.* The Director shall be elected at each annual meeting of the members of the corporation, and shall hold office until the next succeeding annual meeting and until their successors are elected and qualified.

Section 3. *Filling of Vacancies.* Vacancies in the Board of Directors from any cause may be filled by the remaining Directors at any meeting occurring during the unexpired term of the Director with respect to whom such vacancy exists, by a majority vote of the remaining Directors though less than a quorum, provided, however, that if such vacancy exists as to a Director originally nominated by a Participating Hospital Member or by the Rhode Island Medical Society, such Member or Society, as the case may be, shall nominate the successor.

Section 4. *Powers and Duties.* The Board of Directors shall have and exercise the general management and control of the business and affairs of the corporation and shall have and exercise all of the powers which may be exercised or performed by the corporation under the Statutes, the Articles of Association and the by-laws. In furtherance and not in limitation of the foregoing powers, the Board shall have the power (subject always to the specific provisions of these by-laws) to enter into agreements, incur obligations, borrow money and acquire, invest and dispose of property of the corporation (both real and personal, tangible and intangible) without the assent of the members; to adopt such rules and regulations for the proper management of the affairs of the corporation and the conduct of its meetings as the Board shall deem proper; to elect an Investment Committee and such other committees of such membership, and delegate to them such of its powers and duties, as it may deem necessary or desirable; to remove any office or officers at any time in its discretion and fill any vacancy so caused; and to appoint and discharge agents and employees, define their powers and duties, and fix and determine their compensation. Provided, however, that the Board shall not adopt or amend any medical or surgical fee schedule relating to any non-profit medical-surgical plan except with the prior written approval of the House of Delegates of the Rhode Island Medical Society. Failure of the House of Delegates to approve of

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SURGICAL PLAN AFFIDAVIT FILED

Photo shows Secretary of State, Armand H. Cote, accepting affidavit of the Rhode Island Medical Society as presented by Dr. John F. Kenney, president, to permit the Hospital Service Corporation of Rhode Island to administer the surgical insurance plan. Mr. George Davis (at right), member of the board of directors of Blue Cross, representing the public, watches the signing of the document.

HOSPITAL CORPORATION BY-LAWS

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any proposed or amended fee schedule within 45 days after written notice thereof from the Board of Directors shall be deemed to constitute approval thereof."

ARTICLE VI

Contracts of Corporation

"Section 1. • *Limitation on Contracts.* No Director or officer of the corporation shall have any personal financial interest, direct or indirect, in any contract relating to the business conducted by the corporation or the furnishing of supplies to the corporation, unless authorized by the concurring vote of two-thirds of the full Board of Directors; provided, however, that this section shall not limit the right of a hospital of which a Director or an officer of the corporation may be directly or indirectly interested as a member of its staff or otherwise, *or of a participating physician,* to contract with the corporation to furnish hospital or medical-surgical service to its subscribers.

"Section 2. *Contracts for Hospital and Medical-Surgical Service.* Contracts for the rendering of hospital and/or medical-surgical service to subscribers may be made with such eligible hospitals and participating physicians and upon such terms and conditions as the Board of Directors may determine from time to time.

"Section 3. *Subscriber Contracts.* Contracts with subscribers for hospital and/or medical-surgical service shall be in such form and shall be made with such persons as shall be from time to time determined by the Board of Directors."

ARTICLE XII

Amendment of By-Laws

"These by-laws may be amended, added to, altered or repealed, or new by-laws may be adopted by affirmative vote of all of the members of the Board of Directors representing the Participating Hospital Members present at any regular or special meeting and of a majority of the other members of the Board present at such meeting, provided notice that the same is to be considered and acted upon, stating the nature thereof, shall have been included in the notice or waiver of notice of the meeting; and provided further that no amendment of these by-laws reducing the number of the representatives of the Rhode Island Medical Society upon the Board of Directors, or effecting any change whatsoever in the provisions of Sec. 4 of Article III of these by-laws concerning adoption or amendment of the medical or surgical fee schedule, shall be made without the affirmative vote of at least all but one of the members of the Board representing said Society present at such meeting."

DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at the Hearthstone House, East Providence, Rhode Island, on February 27, 1946, at 9 p.m. The meeting was preceded by a dinner given in honor of veteran physicians who are members of the Society.

The meeting was called to order by the President, Dr. William N. Kalcounos. Minutes of the previous meeting were dispensed with. A communication from the Red Cross asking for a donation was read by the Secretary. It was voted to give $25.

Applications for associate membership received from Drs. Arthur B. Cuddy, Reginald Boucher and Raymond T. Stevens were then read by the Secretary.

It was moved and seconded that the Secretary cast one vote for the acceptance of the six new regular members whose applications were presented at the January meeting. These new members are: Drs. Ambrose G. Barry, Arthur A. Helgerson, Edwin F. Lovering, Gordon Marquis, Harold Woodcome and Hrad H. Zooloomian.

Dr. Kalcounos then called upon Dr. J. L. Wheaton to present the report of the nominating committee. His report was as follows:

President: William N. Kalcounos, M.D.
Vice President: Earl J. Mara, M.D.
Treasurer: Laurence A. Senseman, M.D.
Secretary: Kieran W. Hennessey, M.D.
Councilor: J. L. Wheaton, M.D.
Earl F. Kelly, M.D. (alternate)
Delegates: Earl J. Mara, M.D.
Charles L. Farrell, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Standing Committee: Earl F. Kelly, M.D.
G. Raymond Fox, M.D.
Joseph H. Doll, M.D.
Armand A. Bertini, M.D.
Edward H. Trainor, M.D.

Following his report Dr. Wheaton welcomed the veteran physicians and presented those present with honorary certificates on behalf of the society. Twenty of the thirty-three veteran physicians were present, namely, Drs. Louis I. Beaudoin, Duncan H. Ferguson, Edward Foster, John Gordon, Francis Hanley, James Healey, Kieran W. Hennessey, Thad Krolicki, Edwin Lovering, Edmond Laurelli, Edward McCaughey, Marden Platt, Raymond E. Stevens, Raymond T. Stevens, Thomas Sheridan, Edward Thompson, Howard Umstead, Frederick Webster, Harold Woodcome, Hrad Zooloomian.

The meeting was adjourned at 10:30 p.m.

Respectfully submitted,

MARY-ELAINE J. ROHR, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The Kent County Medical Society met March 14, 1946, at 4:30 p. m. at the Toll Gate in Westcott. Dr. Merrill presided.

The minutes of the last meeting were read and recorded as read.

Resolutions of the American Veterans of World War II, "AMVETS" West Warwick Post No. 6 and of the Coventry Post No. 7 of the American Veterans of World War II, both endorsing The Kent County Memoiral Hospital, were received and placed on file.

A communication from the Supervisor of Nurses, Mrs. Mulvey, asking whether or not the Tonsil and Adenoid Clinic would be resumed in

continued on page 303

WILLIAM N. KALCOUNOS, M.D.

Re-elected President of the Pawtucket Medical Association for 1946-47

DISTRICT SOCIETY MEETINGS

continued from page 301

West Warwick was discussed. It was moved and adopted that these clinics should be discontinued as there is no need for them at present.

Dr. Young being absent, there was no available report from the Hospital Committee.

Three new members were voted in. They were: Drs. Jean M. Maynard, Joseph C. Kent and Francis D. Lamb.

The nomination of five members to meet with the P. V. Nurses' Association and the Anti-Tuberculosis League, which had been tabled at the last meeting was left today with the President. The following members were selected: Drs. Royal C. Hudson, Peter Erinakes, George B. Farrell, Joseph Harrop and Stanley Davies.

Copies of a communication from the Washington State Medical Society setting forth their Prepayment Medical Plan Program were distributed, as it was too long for reading.

Dr. Dimmitt, representing Dr. Pitts, reported on the Rhode Island Medical Society Prepayment Medical Care Program for the benefit of the County Society members. If accepted by a majority of members of the Rhode Island Medical Society the plan will be supported by the Blue Cross.

The program as it stands is a service plan and not an indemnity plan, sponsoring the clause of minimum fees taking care of the whole charge for the low income group.

A service plan is the better of service or indemnity plans. The indemnity plan would be the same as that of insurance companies.

The Blue Cross is a non-profit organization. Its allocations have covered the full average cost of ward or semi-private accommodations and also paid extra treatments. It has not accepted proprietary hospitals and its directors have worked with no remuneration. It is not interested in an indemnity program.

Discussion returned to local business on fees. A motion was made and seconded that the Secretary advise the welfare departments of Warwick, Coventry and Cranston that the fee schedule of Kent County physicians is as follows:

Office visit	$3.00
House visit	$4.00
Night visit	$5.00 (7 p. m. - 7 a.m.)

Dr. Beardsley was invited to present colored films of his experiences in India and Burma but was unable to do so as the business meeting had been too lengthy.

The meeting was adjourned and dinner was served. There were thirteen members present.

Guest speaker was Dr. Beardsley.

Respectfully submitted,

JEANNETTE E. VIDAL, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, March 4, 1946. The meeting was called to order by President Paul C. Cook at 8:30 p.m.

Dr. Cook called the attention of the membership present to the fact that there is a group taking post graduate refresher courses in Providence in connection with the Pratt Diagnostic Clinic, and he extended the Association's greeting to the men present at the meeting.

The reading of the minutes of the previous meeting of the Association was omitted. The Secretary reported for the Executive Committee as follows:

At a recent meeting of the Executive Committee four applications for active membership in the Association were reviewed. In addition, one physician, Dr. Marshall Fulton, was reinstated as an active member upon his notification of resumption of practice in this district, and one physician, Dr. John Fracasse, recently returned from military service, was granted a year's leave of absence in order that he may complete a hospital residency.

The Committee voted that all physicians returning from service with the armed forces and applying for membership in the Providence Medical Association shall be exempt from the assessment of dues for the first six months following their election to membership.

The Committee authorized the Committee on Fees to prepare and send to each member of the Association a special questionnaire, and likewise authorized the Committee on a Central Telephone Exchange to prepare and distribute a survey form to assist it in its study.

The Committee voted to recommend two changes in the By-laws to the membership of the Association at its next meeting.

Dr. Cook announced that the Committee consisting of Dr. William O. Rice and Dr. Herbert G. Partridge had submitted a resolution on the death of Dr. John M. Peters, which has been filed with the Secretary. He requested the members present at the meeting to stand for a moment in silent tribute to the memory of Dr. Peters.

The Secretary reported that the Executive Committee recommended for election to active membership in the Providence Medical Association the following men: Drs. Benjamin F. Harley, William J. MacDonald, Henry Miller, Eric F. Turkel.

Dr. William M. Muncy moved the unanimous election of these four applicants. The motion was seconded and passed.

The Secretary reported that the Executive Committee recommended changes in the By-laws of the Association. He read the proposed amendments to the By-Laws.

Amendment of Section 9, Article I, to read:

"There shall be standing committees as follows: Air Pollution, Advisory Committee to the Curative Workshops, Inc.; Entertainment; Ethics and Deportment; Legislation; Medical Milk Commission; Nursing; Preschool Examination; Reading Room; Scientific Program; Tuberculosis; Water Pollution."

continued on page 305

Summary and Conclusions

1 PROGYNON-B, alpha-estradiol benzoate, an estrogen for intramuscular injection has a prolonged duration of action, 0.33 mg. (2000 R.U.) often controlling menopausal symptoms for 8 to 10 days.

2 Being highly potent fewer injections are required. Cost is, therefore, lower than treatment with other natural estrogens.

3 It produces a remarkable sense of well-being and toxic reactions are practically unknown.

4 "Results . . . lead to the conclusion that alpha-estradiol benzoate is the estrogen of choice."[1]

PROGYNON-B

PROGYNON-B is available in ampules of 1 cc. containing 0.083 mg. (500 R.U.); 0.16 mg. (1000 R.U.); 0.33 mg. (2000 R.U.); 1.0 mg. (6000 R.U.); and 1.66 mg. (10,000 R.U.). In boxes of 3, 5, 6, 50 and 100 ampules.

Trade-Mark PROGYNON-B—Reg. U. S. Pat. Off.

1. Eisfelder, H. W.: J. Clin. Endocrinol. **11**:628, 1942.

DISTRICT SOCIETY MEETINGS

continued from page 303

Also, Amendment of Section 3 of Article II, to read:

"Associate membership shall be available to those physicians who are active members of other district societies and who also wish to be affiliated with this Association, and to those members of this Association who, leaving this State for an indefinite period of time, or permanently, desire to retain an affiliation with this Association.

"Interns and residents serving in any approved hospital in the district of the Providence Medical Association will be accepted as Associate members upon application, and shall be exempt from annual dues."

Dr. Jackvony moved that the Association adopt the amendments. Dr. B. Earl Clarke seconded the motion. On a voice vote the motion was adopted.

Dr. Cook called upon Dr. Frank W. Dimmitt, a member of the State Society's Surgical Insurance Committee, who is one of the seven representatives of the Society on the Board of Directors of the Hospital Service Corporation, to discuss the proposed voluntary insurance program.

Dr. Dimmitt reviewed the work that has been done to date in planning for the non-profit surgical insurance plan, and he discussed the relations between the Rhode Island Medical Society and the Blue Cross Organization. He reported on the several meetings that have been held by the House of Delegates, and he cited the action taken by the House regarding a proposed fee table. He expressed the opinion that concessions must be made by the physicians in working out the details of the program, and he particularly stated that the fee schedule must be drawn to benefit the low income group.

Dr. Cook called upon Dr. Alex M. Burgess to preside at a panel discussion on "Acute Respiratory Diseases" in which Drs. Harold G. Calder, Francis B. Sargent, and Morgan Cutts participated.

Dr. Harold G. Calder discussed the subject from the point of view of the pediatrician. He pointed out the relative infrequence, in his experience, of toxic reactions to sulfonamides in children, although some dangers were obviously still present. With respiratory infections, he felt that otitis media should be constantly looked for, and if present, sulfadiazene should be promptly started. With severe laryngo-tracheo-bronchitis, he felt that penicillin is of great value, and should be promptly used.

Dr. Francis B. Sargent, discussing the subject from the point of view of the otolaryngologist, commented on the probable value of sulfadiazene solution, penicillin, of tyrothrycin locally in early upper respiratory infection. He reviewed the various types of respiratory infections, seen during the past winter.

Dr. Morgan Cutts, presenting the point of view of the internist, pointed out the value of trying to decide whether respiratory infections are viral or bacterial in origin. If sulfonamides are to be used they should be given in adequate dosage. It was pointed out that influenzal vaccine may be of protective value, but its period of protection is brief.

Dr. Burgess, Chairman of the panel group, pointed out that a moderate number of patients with bacterial pneumonia can be distinguished, with great difficulty, from those with viral pneumonia, and in these cases specific treatment is well worth a trial.

Following the presentation, there was a brief period for discussion and questioning from the floor.

Attendance: 97.

The meeting adjourned at 10:10.

Collation was served.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The Annual Meeting of the Pawtucket Medical Association was held Wednesday evening, March 20, 1946, at the Biltmore Hotel following a banquet.

Dr. William N. Kalcounos was re-elected President for the ensuing year. Dr. Earl J. Mara was elected Vice-President, Dr. Kieran W. Hennessey, Secretary, and Dr. Lawrence A. Senseman re-elected Treasurer.

The Standing Committee, as follows, was re-elected:

G. Raymond Fox, M.D.
A. A. Bertini, M.D.
Earl F. Kelly, M.D.
Joseph H. Doll, M.D.
Thad. A. Krolicki, M.D.

Elected as Delegates to the Rhode Island Medical Society were:

Charles Farrell, M.D.
Henry Hanley, M.D.
Robert Henry, M. D.
Earl Mara, M.D.

continued on next page

Facsimile of citation awarded by the Pawtucket Medical Association to each of its members serving with the Armed Forces in World War II.

DISTRICT SOCIETY MEETINGS

continued from preceding page

Following the conclusion of the business meeting Dr. Earl Kelly presided as master of ceremonies. Musical selections were offered by Miss Anne Trematozzi accompanied by Miss Louise Windsor.

The Association voted a sum of money to the Children's Heart Association to help send underprivileged children to Camp Westwood, the local Y.M.C.A. camp.

Mr. John E. Farrell, Executive Secretary to the Rhode Island Medical Society, spoke briefly. He lauded the progressive aims of the local medical societies in Rhode Island and stated that they have served as examples for other medical groups throughout the country.

Dr. James L. Wheaton was presented with a scroll, and a pen and pencil set in appreciation of his fifty years of exemplary service to the profession and the community.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

N. E. HOSPITAL ASSEMBLY

continued from page 290

pital, Cleveland, Ohio, whose subject covered costs of hospital operation together with increased rates for the care of patients. Dr. Carter stated that with the increasing costs of hospital care, it was his conviction that the daily expense per patient would, within a very short time double that of the pre-war years, this being due to the increased salaries and wages and higher costs for all materials used within the hospitals. The question of how these increased expenses are to be met is one for every hospital to ponder. If the prediction of a one hundred per cent increase over pre-war years is reached, the cost per day for care of patients in the average institution will exceed $12.00 per day, and although many patients can afford to meet their hospital expenses, the institution must more and more depend upon public funds or Blue Cross Plans for meeting their current expenses.

Construction Session

The final meeting of the Assembly was devoted to a round table discussion on construction. The Panel consisted of the leading hospital architects and Hospital Consultants from the larger cities of the New England states.

It was predicted by the architects present that the cost of hospital construction per cubic foot would be double that of pre-war years, and that it is not likely to change for at least the succeeding five years, with the possibility of higher prices continuing from seven to ten years from the present time.

The final business session elected Dr. Arthur H. Ruggles as Trustee from Rhode Island and Miss Helen Blaisdell was continued on the Program Committee. Mr. Carl A. Lindblad will continue on the Board of Trustees as Past-President.

WELCOME HOME

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of April 1. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

JOSEPH A. BAUTE, M.D., 4547 Post Road, East Greenwich

J. MURRAY BEARDSLEY, M.D., 82 Waterman Street, Providence

ALPHONSE R. CARDI, M.D., 1303 Cranston Street, Cranston 9

PASQUALE J. CELESTINO, M.D., Main Street, Hope Valley

PAUL COHEN, M.D., 99 Main Street, Woonsocket

EDWARD DAMARJIAN, M.D., 972 Broad Street, Providence

JOHN S. DZIOB, M.D., 200 Olney Street, Providence

MARSHALL FULTON, M.D., 124 Waterman Street, Providence

FRANCIS E. HANLEY, M.D., 336 No. Broadway, East Providence

WALDO O. HOEY, M.D., 93 Eddy Street, Providence

LOUIS D. LIPPITT, M.D., 41 Pocasset Avenue, Providence

FRANK B. LITTLEFIELD, M.D., 199 Thayer Street, Providence

CECIL J. METCALF, M.D., 198 Angell Street, Providence

HENRY MILLER, M.D., 180 Wayland Avenue, Providence

FRANCIS NEVITT, M.D., 659 Hope Street, Providence

NATHAN S. RAKATANSKY, M.D., 52 Gladstone Street, Providence

RALPH D. RICHARDSON, M.D., 68 Brown Street, Providence

ERNEST D. THOMPSON, M.D., 199 Thayer Street, Providence

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Reports of Special Meetings held February 24, March 3, and March 10

A SPECIAL meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Sunday, February 24, 1946. The following delegates were in attendance:

Abbate, Rocco, M.D.	Fox, A. Henry, M.D.
Callahan, James C., M.D.	Giura, Arcadie, M.D.
Dufresne, Walter J., M.D.	Harrington, Peter F., M.D.
Mara, Earl J., M.D.	Horan, William, M.D.
Sprague, Stanley, M.D.	Jackvony, Albert H., M.D.
Baldridge, Robert, M.D.	Martin, Arthur E., M.D.
Bishop, E. Wade, M.D.	Matteo, Frank I., M.D.
Burgess, Alex. M., M.D.	O'Rourke, Patrick I., M.D.
Buxton, Bertram H., M.D.	Porter, Emery M., M.D.
Clarke, B. Earl, M.D.	Johnson, Linwood, M.D.
Cook, Paul C., M.D.	Pitts, Herman C., M.D.
Cutts, Frank, M.D.	Buffum, William P., M.D.
Davis, William P., M.D.	Cutts, Morgan, M.D.
Famiglietti, Edward V., M.D.	Ashworth, Charles J., M.D.

Also in attendance were Dr. Philip Batchelder, Dr. Frank W. Dimmitt and John E. Farrell, Executive Secretary.

In the absence of the president and the vice-president, Dr. Herman C. Pitts presided. He stated that the purpose of the meeting was to discuss matters incidental to the development of the Voluntary Surgical Insurance Program in Rhode Island. He first called upon Mr. Williamson, legal counsel, engaged by the Society to report on the scope of the Enabling Act.

Mr. Williamson briefly reviewed the terms used in the legislation authorizing the establishment of the non-profit medical service corporation, and he reported on the findings of the legal consultants who had reviewed the law in an effort to determine its scope. The conclusion of the legal firm of Edwards and Angell with whom he is affiliated were as follows:

"It is our opinion, therefore, that the courts should, and probably would, limit the words 'duly licensed' in the Enabling Act to those who have received a certificate to practice 'medicine and surgery'. This would exclude osteopaths and chiropractors who receive a certificate to practice osteopathy or chiropractic.

"Under the other construction, namely, that the words 'duly licensed' means 'authorized by law', we believe that osteopaths who can qualify under the statute to practice 'any branch of surgery' have a prima facie case that they come within the meaning of this definition. A chiropractor, whose practice is limited to 'minor surgery' and does not permit the prescription of drugs, would in our opinion be excluded therefrom. The case of an osteopath who is authorized to practice only 'minor surgery' is doubtful, but probably he would be excluded also.

"The Illinois legislature has attempted to meet this problem in recent legislation adopting a medical service plan. Subsec. 7, Chap. 32-569, of the Rev'd. Laws of Illinois, 1945, provides as folows:

> "'Every physician licensed in Illinois to practice medicine in all its branches, and who is reputable and in good standing, shall be eligible to become a participating physician in the medical service plan corporation operating in the country in which he resides or practices, under such terms and conditions as are imposed on other participating physicians under similar circumstances.' (Italics ours)

"This statute under our laws would, we believe, produce the same result as we have indicated herein.

"As a practical matter, it would seem necessary to the public welfare to provide in the by-laws of such medical service corporation that no physician could participate in such plan without the approval of the Rhode Island Medical Society.

The conclusions advanced by the legal firm were discussed by members of the House, after which the following motion was made:

> The House of Delegates of the Rhode Island Medical Society instructs its elected representatives on the board of the Hospital Service Corporation to request that Corporation to amend its by-laws to provide that only physicians having a certificate to practice medicine and surgery be declared eligible as contracting physicians under the Voluntary Surgical Insurance Plan.

The motion was seconded and unanimously passed.

Dr. Philip Batchelder raised the question of the position of the dentists in view of the fact that dental surgery might be encompassed under the program. Mr. Williamson reported that the Hospital Service Corporation does not plan to have any contracts with dentists at this time.

Dr. Pitts reported the result of the mail ballot to the House of Delegates for the purpose of electing nominees to be submitted to the Hospital Service Corporation for election as representatives of the Society on its Board of Directors. He stated that the following physicians had been nominated and subsequently elected by the Hospital Service Corporation: Dr. Samuel Adelson of Newport, Dr.

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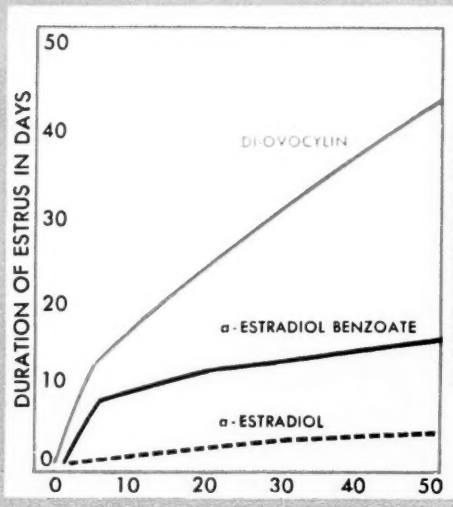
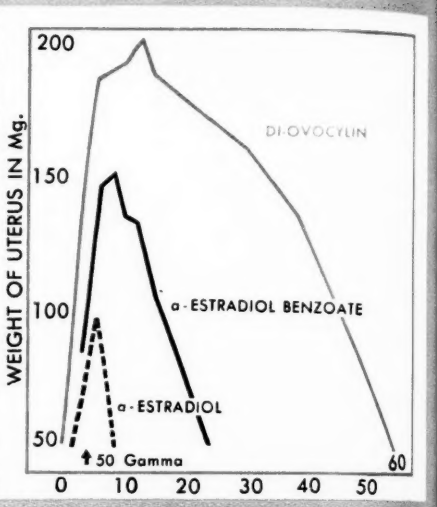


Duration of estrus produced in castrated rats by estradiol, estradiol benzoate, and estradiol dipropionate.



Effect of estradiol, estradiol benzoate, and estradiol dipropionate on the uterine weight of castrated rats.

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Used in conditions such as vulvovaginitis of infants, senile vaginitis, pruritus vulvae. Supplied: Suppositories of 0.04 mg., boxes of 10 (Adult's size) and 30 (Children's size); 0.4 mg., boxes of 10 (Adult's size).

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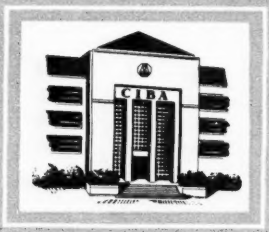

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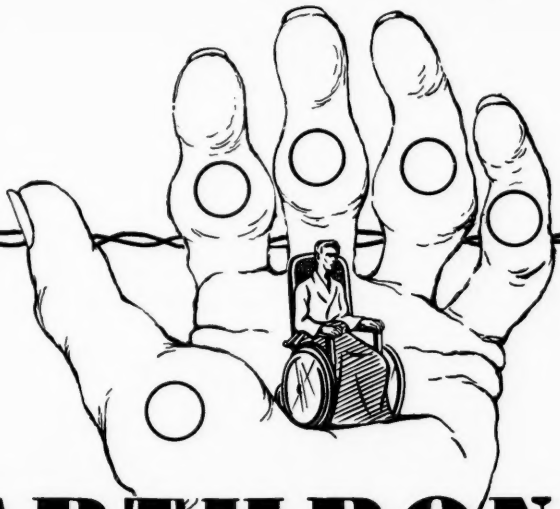

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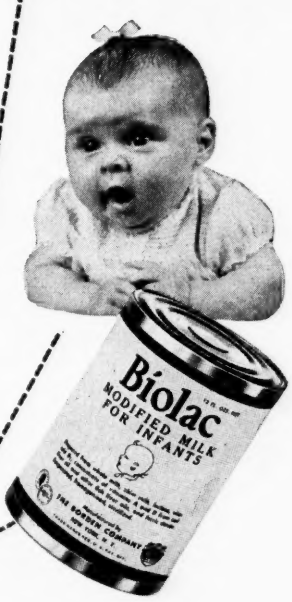

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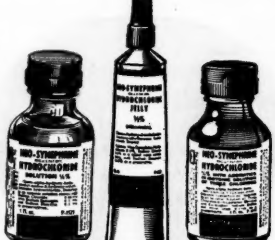

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HOUSE OF DELEGATES
of the
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Mara, Earl J., M.D.	Horan, William, M.D.
Sprague, Stanley, M.D.	Jackvony, Albert H., M.D.
Baldridge, Robert, M.D.	Martin, Arthur E., M.D.
Bishop, E. Wade, M.D.	Matteo, Frank I., M.D.
Burgess, Alex. M., M.D.	O'Rourke, Patrick I., M.D.
Buxton, Bertram H., M.D.	Porter, Emery M., M.D.
Clarke, B. Earl, M.D.	Johnson, Linwood, M.D.
Cook, Paul C., M.D.	Pitts, Herman C., M.D.
Cutts, Frank, M.D.	Buffum, William P., M.D.
Davis, William P., M.D.	Cutts, Morgan, M.D.
Famiglietti, Edward V., M.D.	Ashworth, Charles J., M.D.

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In the absence of the president and the vice-president, Dr. Herman C. Pitts presided. He stated that the purpose of the meeting was to discuss matters incidental to the development of the Voluntary Surgical Insurance Program in Rhode Island. He first called upon Mr. Williamson, legal counsel, engaged by the Society to report on the scope of the Enabling Act.

Mr. Williamson briefly reviewed the terms used in the legislation authorizing the establishment of the non-profit medical service corporation, and he reported on the findings of the legal consultants who had reviewed the law in an effort to determine its scope. The conclusion of the legal firm of Edwards and Angell with whom he is affiliated were as follows:

"It is our opinion, therefore, that the courts should, and probably would, limit the words 'duly licensed' in the Enabling Act to those who have received a certificate to practice 'medicine and surgery'. This would exclude osteopaths and chiropractors who receive a certificate to practice osteopathy or chiropractic.

"Under the other construction, namely, that the words 'duly licensed' means 'authorized by law', we believe that osteopaths who can qualify under the statute to practice 'any branch of surgery' have a prima facie case that they come within the meaning of this definition. A chiropractor, whose practice is limited to 'minor surgery' and does not permit the prescription of drugs, would in our opinion be excluded therefrom. The case of an osteopath who is authorized to practice only 'minor surgery' is doubtful, but probably he would be excluded also.

"The Illinois legislature has attempted to meet this problem in recent legislation adopting a medical service plan. Subsec. 7, Chap. 32-569, of the Rev'd. Laws of Illinois, 1945, provides as folows:

> "'Every physician licensed in Illinois to practice medicine in all its branches, and who is reputable and in good standing, shall be eligible to become a participating physician in the medical service plan corporation operating in the country in which he resides or practices, under such terms and conditions as are imposed on other participating physicians under similar circumstances.' (Italics ours)

"This statute under our laws would, we believe, produce the same result as we have indicated herein.

"As a practical matter, it would seem necessary to the public welfare to provide in the by-laws of such medical service corporation that no physician could participate in such plan without the approval of the Rhode Island Medical Society.

The conclusions advanced by the legal firm were discussed by members of the House, after which the following motion was made:

> The House of Delegates of the Rhode Island Medical Society instructs its elected representatives on the board of the Hospital Service Corporation to request that Corporation to amend its by-laws to provide that only physicians having a certificate to practice medicine and surgery be declared eligible as contracting physicians under the Voluntary Surgical Insurance Plan.

The motion was seconded and unanimously passed.

Dr. Philip Batchelder raised the question of the position of the dentists in view of the fact that dental surgery might be encompassed under the program. Mr. Williamson reported that the Hospital Service Corporation does not plan to have any contracts with dentists at this time.

Dr. Pitts reported the result of the mail ballot to the House of Delegates for the purpose of electing nominees to be submitted to the Hospital Service Corporation for election as representatives of the Society on its Board of Directors. He stated that the following physicians had been nominated and subsequently elected by the Hospital Service Corporation: Dr. Samuel Adelson of Newport, Dr.

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G. Raymond Fox of Pawtucket, Dr. Frank W. Dimmitt, Dr. Albert H. Jackvony, Dr. Philip Batchelder and Dr. William P. Davis, all of Providence.

There was a discussion of the question of staggering the term of office for the medical representatives on the Board of Directors in accordance with the proposal of the House of Delegates at its last meeting. Dr. Mara moved that the House defer the staggering of the terms of the representatives until the time for the next election of representatives to the Hospital Service Corporation's Board of Directors. The motion was seconded. After discussion Dr. Pitts called for a vote on the question. The motion failed its passage.

Dr. Abbate moved that the staggering of the terms of the representatives of the Society of the Board of Directors of Blue Cross be determined by the President of the Society in order to provide for continuity. The motion was seconded and passed.

Dr. Pitts raised the question of the authority to be given the representatives on the Board of Directors. Dr. Buffum expressed the opinion that the House of Delegates should give these representatives broad powers in order to provide for the success of the program.

Dr. P. F. Harrington moved that the members elected by the Society to serve as representatives on the Board of Directors of Blue Cross be given the power to act for the House of Delegates in matters regarding the Surgical Insurance Plan, and that they also report in writing on their work at each meeting of the House of Delegates. The motion was seconded and passed.

Dr. Pitts opened the discussion regarding the proposed surgical fee schedule for the insurance plan. He stated that copies of the proposed schedule had been sent to each delegate, and he further reported that the table represented the preliminary findings of members of the Society representing the various specialties who had compiled the list on the basis of the Massachusetts and Michigan Medical Service Plans, the Workman's Compensation Schedule used by the Rhode Island Hospital, and the prevailing fees in the community.

Discussion was initiated on the obstetrical and gynecological fee table. Dr. Dufresne moved that the obstetrical fee be set at $50.00 insteal of $40.00 as listed on the proposed schedule. The motion was seconded and passed.

Dr. Baldridge noted an inconsistency in one listing of fees and, therefore, moved that all caruncles

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be listed at a fee of $25.00. The motion was seconded and passed.

Dr. Pitts moved that the fee for the caesarean section be $150.00. The motion was seconded and passed.

Dr. Jackvony moved that the House adopt the obstetrical and gynecological fee schedule as listed on page 1 of the proposed schedule with the three corrections already noted, and he also moved to accept page 2 of the proposed schedule with the exception of the anesthesia fee. The motion was adopted.

There was discussion regarding the fee to be allowed for anesthesia and finally Dr. Harrington moved that the House report to the anesthetists submitting the fee that it is too high for the proposed surgical plan and that the House asks for a reconsideration of these fees. The motion was seconded and passed.

Dr. Pitts suggested that the various specialty groups be asked to consider the fees applicable to their specialties and to report back their decisions to the House of Delegates at the next meeting. He suggested that Dr. Martin check with the orthopedists, Dr. Dimmitt with the eye, ear, nose and throat doctors, Dr. Baldridge with the urologists and Dr. Batchelder with the radiologists. Dr. Batchelder sought information on the question of X-ray both in and out of the hospital. After discussion it was determined that it would be agreeable to have the radiologists recommend what they feel is a fair fee, and it was suggested that a maximum of $15.00 in any one contract might be offered as indemnity towards the total bill.

There was a discussion of fee schedules in other states, and Dr. Burgess, offering his motion as a test to determine the attitude of the House, moved that it adopt the Michigan Fee Schedule as it is now written. The motion was seconded, but on a voice vote was defeated.

Dr. Pitts called for a decision as to when the House might again meet in special session, and it was the consensus that the next meeting should be held on Sunday, March 3, at 11 a.m. at the Medical Library.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

* * *

A special meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Sunday, March 3, 1946. In the absence of the President, the meeting was called to order by Vice-President Joseph H. Ladd at 11 a.m. The following delegates were in attendance:

Rocco Abbate, M.D.
Samuel Adelson, M.D.
Walter J. Dufresne, M.D.
Earl J. Mara, M.D.
Stanley Sprague, M.D.
Robert Baldridge, M.D.
E. Wade Bishop, M.D.
Alex M. Burgess, M.D.
Bertram H. Buxton, M.D.
Harold G. Calder, M.D.
Paul C. Cook, M.D.
Frank Cutts, M.D.
George W. Davis, M.D.
William P. Davis, M.D.
Edward V. Famiglietti, M.D.
William Horan, M.D.
Albert H. Jackvony, M.D.
Arthur E. Martin, M.D.
Frank I. Matteo, M.D.
Patrick I. O'Rourke, M.D.
Emery M. Porter, M.D.
George Waterman, M.D.
Linwood Johnson, M.D.
Herman C. Pitts, M.D.
Joseph H. Ladd, M.D.
William P. Buffum, M.D.
Charles J. Ashworth, M.D.

Also in attendance were the following:

John E. Farrell
Herman P. Grossman, M.D.
Morris Botvin, M.D.
Lee G. Sannella, M.D.
H. Frederick Stephens, M.D.
William M. Muncy, M.D.
John A. Hayward, M.D.
William N. Kalcounos, M.D.
Philip Batchelder, M.D.
Samuel Nathans, M.D.
Cecil J. Metcalf, M.D.

Dr. Ladd stated that the officers of the Society had invited Mr. Stanley H. Saunders, Executive Director of the Hospital Service Corporation, to be

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present to outline the organizational problems of the Surgical Insurance Program. He invited Mr. Saunders to address the House.

Mr. Saunders reviewed the progress of the Blue Cross organization since its inception in Rhode Island and then discussed its problems in connection with the merchandising of the Surgical Insurance Plan. He stated that it would not be possible for Blue Cross to sell the plan unless the premium rate is one that the public can pay, and he expressed the opinion that one thing in particular will make or break the plan and that is the ability to enroll in sizeable numbers those persons in the lower income groups. He expressed the opinion that if the plan is to be useful it must reach these groups.

Mr. Saunders discussed at length the agreements between the Blue Cross and the Society and stated that the former was very much interested in the fee schedule for if it is not in line with other plans, a higher premium would have to be charged before the program would receive the approval of the insurance commissioner, and a higher premium would make the selling of contracts in any appreciable number a difficult task.

In answer to inquiries from the House Mr. Saunders expressed opposition to any proposal to inflate the fee schedule and then to pro rate the fees on the basis of actual income. He stated that he believed that such a procedure would not be fair to the plan and it would also disillusion physicians who would continue to receive less than the stipulated fee. He expressed the opinion that the physicians should appreciate the task of drafting a fee schedule with the main thought that it is only for those in the low income groups, and for all other persons it is an indemnity schedule.

Dr. Ladd reported that the representatives of the Society serving on the Board of Directors of the Blue Cross had had a meeting with the officials of that organization within the week, and he called upon Dr. Dimmitt for a report. Dr. Dimmitt reported as follows:

"Drs. Davis, Adelman, Jackvony, Batchelder, and Dimmitt met with Messrs. MacColl, Davis, Saunders, and Clapp of the Blue Cross, Wednesday afternoon, February 27, 1946. Mr. Saunders and Mr. MacColl gave a resume of the history, development, and present standing of the Blue Cross and pointed out that the stage is set for large-scale enrollment of Blue Cross members under the proposed Surgical Plan.

"It appears that the most important consideration to insure the success of this venture is that the premium

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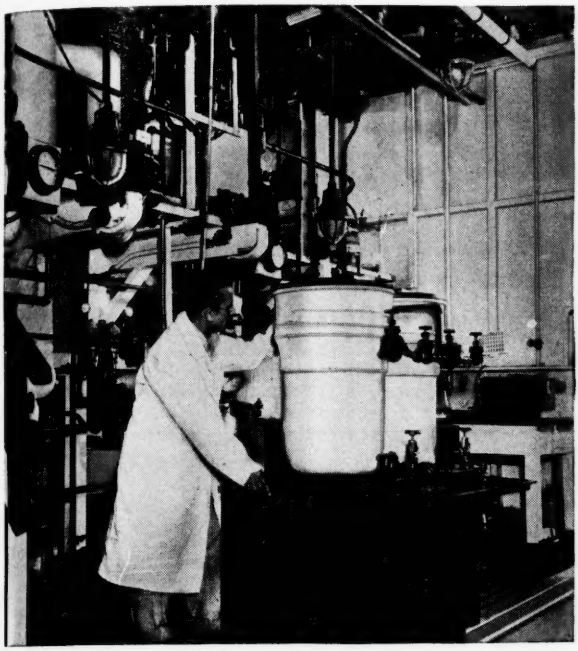

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must be low enough to make the contracts readily saleable in competition with commercial insurance companies. At the present moment two large industrial plants, employing as I recall it about 4800 individuals, are anxiously awaiting the announcement of our plan. They are being urged to purchase contracts for their employees with commercial insurance firms, but are holding off to see what the Blue Cross has to offer.

"Very definitely it will be to our advantage, if our fee schedules can be completed promptly so that the Blue Cross can compute its premium rates and get into the market to sell contracts as soon as possible. It seems that our fee schedule as approved to date and as contemplated is above all others, even that of New York in several instances. It appears to me and perhaps to the other doctors on the Board that we must make some concessions in order to avoid jeopardizing the success of the Plan by forcing the adoption of too high a premium rate.

"Careful analysis shows little foundation for the fear that if we adopted fairly low fees at first, it will be impossible to raise them later. The other view, that it is advisable to begin with very reasonably low fees and raise them later if necessary, seems more proper."

Dr. Ladd called for a general discussion and several members of the House proposed questions which Mr. Saunders answered.

Dr. Adelson of Newport addressed the House to state that in his opinion if the Medical Society is to cooperate with the Blue Cross, the Corporation must change its attitude of feeling that it does not need the surgical plan to augment its services to the people. He cited that the Medical Society is accepting the responsibility in the Surgical Insurance Program as a service to the community and is not seeking any particular advantages or fees to itself. Mr. Saunders replied that he did not wish anyone to miscosstrue the desire of the Blue Cross to cooperate with the Medical profession in working out any of the details of the Program for it is interested in doing a good job for the community.

Dr. Ladd thanked Mr. Saunders in behalf of the House for his kindness in addressing them and answering the inquiries posed.

Dr. Ladd called for reports of the Committee chairmen of the various specialty groups who have studied the fee tables for their particular sections. Dr. Arthur E. Martin submitted a report from the orthopedic physicians, Dr. Frank Dimmitt for the eye, ear, nose and throat specialty group, Dr. Batchelder for the radiologists, Dr. Metcalf for the anesthetists, and Dr. Baldridge for the urologists.

Dr. Frank B. Cutts moved:

"That in general the Rhode Island Surgical Insurance Plan have no fee for any operation or procedure which shall exceed the highest fee for this operation or procedure to be found in the schedules of the New York, Massachusetts, Michigan or New Jersey voluntary surgi-

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cal care plans; and provided further that any exception to this general rule must be hereafter individually considered and the fee approved by a two-thirds majority of the Delegates at a stated meeting."

The motion was seconded.

Dr. Adelson moved to amend the motions to provide that a fee for the assistant be exclusive of the fee paid to the surgeon. The motion was seconded.

Dr. Mara questioned the provision of the requirement for a two-thirds majority of the House and expressed the opinion that the decision should be left to a majority.

After a discussion of the motions before the House Dr. Adelson withdrew his motion and Dr. Dufresne, his seconding of it. Thereupon, Dr. Ladd called for a vote of the motion placed before the House by Dr. Frank Cutts. The motion was adopted.

Dr. William P. Buffum moved that the seven representatives of the Society on the Board of Directors of the Hospital Service Corporation act as a Committee to arrange a tentative fee schedule consistent with the motion just adopted by the House, and that such schedule shall be submitted to the Society. The motion was seconded and passed.

Dr. Ladd asked for an expression of opinion as to when the next meeting of the House should be held. The consensus was that the House should reassemble on Sunday, March 10, at 11 a.m. at the Medical Library.

The meeting adjourned at 1:10 p.m.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

* * *

A special meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Sunday, March 10, 1946. The meeting was called to order at 11:05 a.m. by Vice President Joseph H. Ladd in the absence of President John F. Kenney. The following members of the House were in attendance:

Rocco Abbate, M.D.	Albert H. Jackvony, M.D.
Samuel Adelson, M.D.	Arthur E. Martin, M.D.
Earl J. Mara, M.D.	Frank I. Matteo, M.D.
Joseph L. Turner, M.D.	Anthony V. Migliaccio, M.D.
Robert Baldridge, M.D.	Patrick I. O'Rourke, M.D.
Peter Pineo Chase, M.D.	Emery M. Porter, M.D.
Paul C. Cook, M.D.	George Waterman, M.D.
Frank Cutts, M.D.	Robert H. Whitmarsh, M.D.
George W. Davis, M.D.	Linwood Johnson, M.D.
William P. Davis, M.D.	Herman C. Pitts, M.D.
Edward V. Famiglietti, M.D.	Joseph H. Ladd, M.D.
Arcadie Giura, M.D.	Morgan Cutts, M.D.
William Horan, M.D.	Charles J. Ashworth, M.D.

The executive secretary of the Society, Mr. Farrell, reported on a meeting scheduled for the following day by the Governor's Commission to study the R. I. Cash Sickness Compensation Act. He stated that the Society had been asked to send representatives to this hearing to express the views of the profession.

Dr. R. Abbate recommended that appointed delegates be named to represent the Society.

> A motion subsequently made that Dr. Herman C. Pitts and Mr. John E. Farrell attend the hearing and make known the views of the Society, and also that any other member of the House of Delegates finding it possible to attend the hearing be urged to do so.

The motion was seconded and passed.

Dr. Ladd stated the special session had been called to continue discussion of the proposed surgical insurance plan. He called for a report from the special committee assigned to the revision of the proposed fee schedule.

Dr. Albert H. Jackvony reported that the Committee had prepared a tentative schedule, copy of which was available for each Delegate. Dr. Dimmitt directed attention to the fact that no action had been taken by the committee relative to additional fees for specialists, and Dr. William P. Davis reminded the House that the committee had made no attempt to establish fees, but had merely checked the Massachusetts, New Jersey, New York, and Michigan voluntary surgical plans' fee tables to make sure that no fee in the proposed Rhode Island table was higher than the maximum for the same operative procedure as listed in these schedules.

Dr. Charles J. Ashworth addressed the House, pointing out that very few of the physicians were acquainted with the many differences existing between a service program and an indemnity program. He reported at length on a complete report published by the Warren County (Pennsylvania) Medical Society citing the dangers of a service type of program. He stated further that he believed all the problems regarding a fee table would be solved if an indemnity plan were adopted, and

> He moved that before any action was taken on the adoption of a surgical plan reconsideration be given to the advantages and the disadvantages of both service and indemnity plans.

The motion was seconded.

In the discussion that followed on this motion, Dr. Adelson expressed objection to its adoption, stating that the House should not prolong the study further. Citing the need for consideration of the low income group for the service type of program he urged defeat of the motion. Dr. Pitts supported Dr. Adelson. Dr. Anthony V. Migliaccio briefly reviewed the advantages of the indemnity plan and read the following comment printed in the Warren County (Pennsylvania) Medical Society report:

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"It is a very significant fact that most plans formed in the early days (1939 through 1942) violated the directives of the A.M.A. and were service-type plans: California, Colorado, Massachusetts, Michigan, New Jersey, and New York City; whereas plans formed since have, almost without exception, been indemnity type:

Connecticut	North Carolina
Cleveland, Ohio	Central New York
Delaware	Western New York
Kansas City area	Ohio (State)
Minnesota	Oklahoma
Missouri	Texas
Nebraska	Toledo, Ohio
New Hampshire	Utah

Dr. Ashworth stated it would be better that the House take time now to investigate fully the better type of plan than to discover shortcomings in the program at a later date. He maintained that the service type of program would socialize medicine at the state level. He read from the Warren County report as follows:

"Service-type plans, then, are seen to introduce these non-insurance elements:

"1. The intrusion of a third party between patient and physician, and the disruption of the time-honored individual patient-physician relationship.

"2. The dependence by the assured upon a corporation or other organization, rather than upon individual or group practitioners of medicine, to provide adequate medical care.

"3. The control of the profession by the insuring organization, through the introduction of the employer-employee relationship between the organization and the individual practitioner.

"4. A so far invariable reduction of fees below the average, ordinary fees charged the average, ordinary, private patient.

"5. The limitation of the practitioner to the remuneration originally contracted for, no matter what the complications nor the amount of care necessary to be rendered a particular case.

"6. The protection of the insurance company against loss by making the individual doctors agree to shoulder any such.

"7. The substitution of the corporate and contract practice of medicine for the present system of the private individual practice of medicine."

Dr. Pitts read the following pro and con statements regarding the service vs. indemnity plan as listed by the Blue Cross:

"Would it not be preferable to offer a cash indemnity plan instead of a plan which provides full service for those persons below a certain income limit?

YES	NO
BECAUSE	BECAUSE
1. cash indemnity eliminates the need of an income limit and enables the doctor to charge whatever he wishes.	1. the doctors and Blue Cross would be offering nothing more than insurance companies now offer to the public. Unless a program can be devised that more adequately meets the needs of the public, the job might well be left to commercial insurance companies.
2. it would be easier	

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Dr. Ladd called for a voice vote on Dr. Ashworth's motion. The vote was given and the Chair ruled the motion adopted. Dr. Pitts called for a show of hands on the vote. The vote was 10 for adoption and 10 opposed.

Dr. William P. Davis called to the attention of the House that the voluntary hospitalization plan is operated on an indemnity basis. After further discussion Dr. Ladd called for a standing vote on the motion. *The vote was 11 for adoption and 12 opposed, and therefore the Chair ruled the motion defeated.*

Dr. Anthony V. Migliaccio

> moved that the House of Delegates take no final action on the problem of insurance until the Medical Society has had an opportunity to express itself; and further, that the House of Delegates carry out the wish of the Society when that wish is made known.

Dr. Mara seconded the motion.

In the discussion of the motion, Dr. Mara pointed out that many physicians were opposed to the planned program because they had but limited knowledge of it, and therefore would object to signing a contract to render the service proposed. He stated that many physicians do not attend the meetings of either the state or their district society and therefore some method must be found to reach them directly that they may be informed. Dr. Johnson of Westerly stated most of the Washington County physicians were in favor of the plan. Dr. Adelson reported that the Newport County Society hopes to have some of the authorities best informed of the program address them at their next meeting. Dr. Mara discussed briefly the question of fees as paid physicians in Pawtucket. Dr. William P. Davis stated he felt definitely that the House should approve or disapprove the plan together with the fee schedule proposed and then place the matter before the entire Society. Dr. Johnson inquired what would be the attitude if a compulsory plan was established by the federal government, and Dr. Migliaccio answered expressing the belief that the federal plan would be better in so far as the personal income of the physician would be concerned. Dr. Whitmarsh expressed favor with the recommendation that effort be made to educate the members of the profession through their district societies regarding the proposed voluntary program of the Society. Dr. Emery M. Porter stated very few physicians know much about the mechanics of the program as the details are not clear. He expressed the belief that the House should settle on the fee schedule, submit it to the Blue Cross, and once rates are set submit the entire proposition to the Society for a decision.

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PORTLAND • PITTSBURGH • FT. WORTH • NOTTINGHAM • TORONTO • SO. AFRICA

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Dr. Ladd called for a voice vote on Dr. Migliaccio's motion. The vote was for adoption with no dissenting vote expressed.

Dr. Robert R. Baldridge moved that the benefits to be given the public under the plan now under consideration shall be limited by the four plans studied.

Dr. Migliaccio seconded the motion and read a tabulation of fees for various voluntary surgical plans in the country.

After discussion of the motion Dr. Baldridge withdrew it to allow Dr. Migliaccio to submit a

revised motion that benefits allowed by any Rhode Island surgical plan shall be limited by the benefits in any of the four plans used in preparing the tentative fee schedule, provided this fee schedule is adopted.

The motion was seconded by Dr. Mara.

The motion was discussed. Dr. Adelson cited that only EENT men can do tonsillectomies at Rhode Island Hospital as well as other hospitals, and it would be unfair to deny the right to a patient to consult the doctor of his choice, whether a specialist or not, for the operative procedures to be covered by the proposed plan. Dr. Mara maintained that Blue Cross wants to sell a better offer at a lower price than any other voluntary surgical plan in the country.

Dr. Ladd called for a voice vote on Dr. Migliaccio's motion. The motion was defeated.

Dr. Emery M. Porter moved that the House reconsider its previous action relative to the allowance of $300 for each dependent in establishing the income groups.

The motion was seconded. On a voice vote the motion was adopted.

Dr. Migliaccio moved that the House of Delegates go on record as adopting the fee schedule as presented by the committee.

The motion was seconded. After discussion Dr. Migliaccio withdrew the motion with permission to reintroduce it later in the meeting.

Dr. Dimmitt discussed the question of additional fees for specialists, and reported on the fees established for the tonsillectomy and adenoidectomy. Dr. William P. Davis called attention to the listing in the proposed fee schedule of the letter NL after certain fees, and he explained these fees and the procedures for which the fees were listed, were not found in any of the schedules studied by the committee.

Dr. Waterman cited that additional fees for specialists should be eliminated, and he moved

that the fee schedule should stand as proposed except that no additional fee should be allowed for the services of specialists. The motion was seconded and adopted.

Dr. Anthony V. Migliaccio moved that the Society's representatives on the Blue Cross corporation be authorized to set fees for any procedures not listed by the other plans studied. The motion was seconded and adopted.

Dr. Rocco Abbate moved that the tonsillectomy and adenoidectomy fee be $35 for children under 15 years of age, and $40 for adults. The motion was seconded.

Dr. Ladd called for a standing vote on the motion. The vote was four in favor, and four opposed. (Several did not vote.)

The question was briefly discussed further and a second standing vote was called by the Chair. The vote was six in favor and four opposed, and the motion was declared adopted. (Several did not vote.)

Dr. Adelson

moved that the assistant's fee be set at the same rate as the anesthetist's fee. The motion was seconded and adopted.

Dr. Anthony V. Migliaccio

reintroduced his motion that the House adopt the fee schedule as proposed with the changes as indicated by the House, and with such changes as may be made by the committee in establishing the non-listed (NL) fees indicated in the proposed schedule. The motion was seconded and adopted.

The House adjourned at 2:05 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Assistant Secretary*

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* Tuohy, E. L.: In *Handbook of Nutrition*, A. M. A., Chicago, 1943, p. 380.

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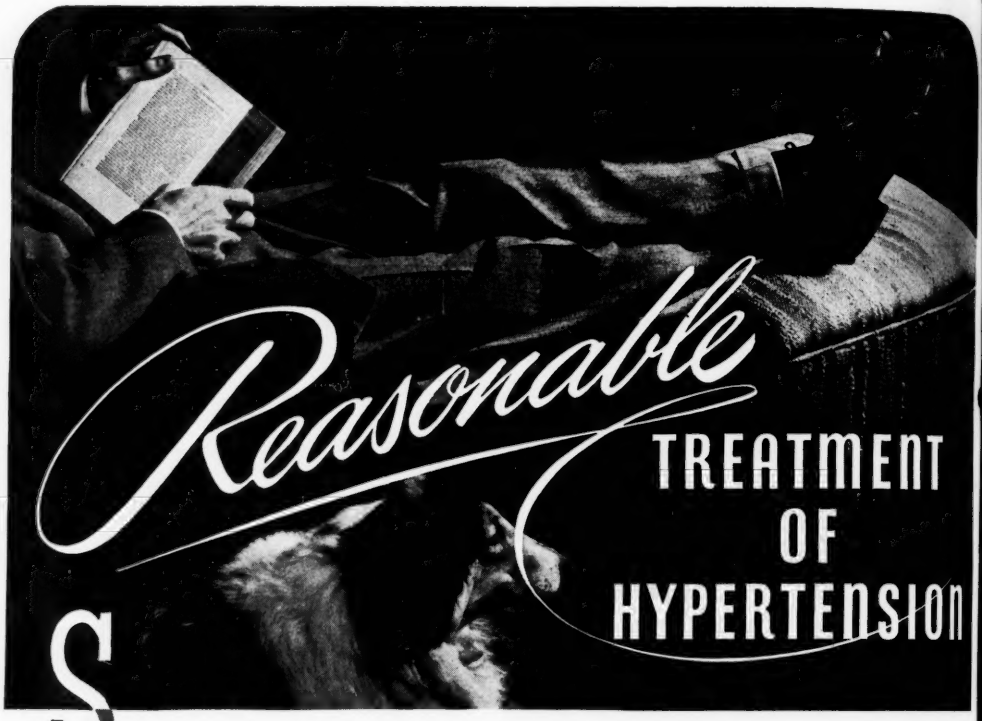

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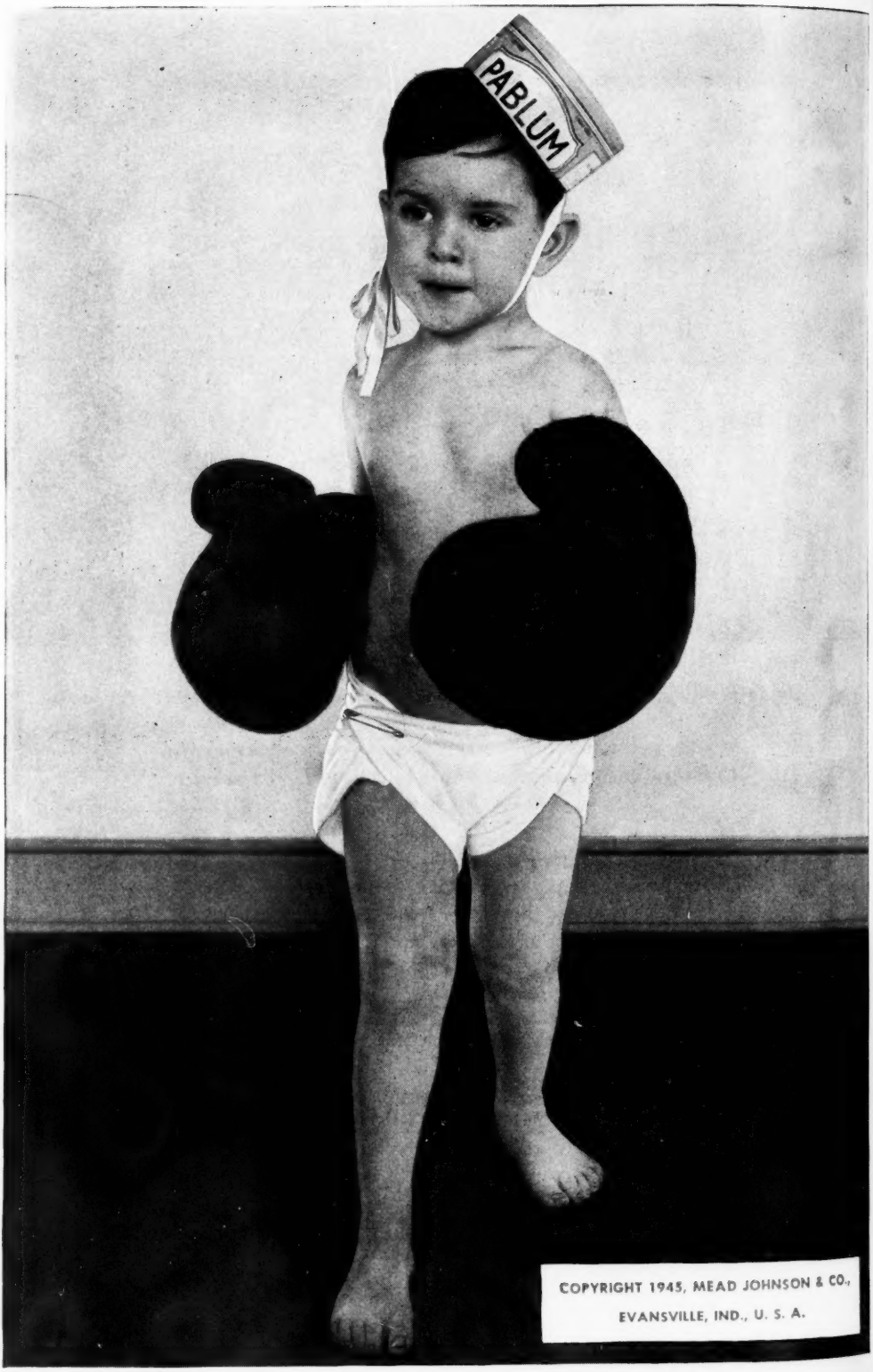
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